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JOURNAL of the MISSISSIPPI State Medical Association

This Month:

Treatment of Recurrent Brain Tumors With Intra-Arterial Cis-Platinum and BCNU

Developmentally Inverted Appendix Presenting as Cecal Polyp: Case Report

Heroics and Heretics: Medical Practice in Antebellum Mississippi

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NEWSLETTER

January 1984

Dear Doctor:

Physicians are being warned of a telephone marketing scheme which falsely claims connection with the AMA and American Medical News. Physicians who receive such calls are urged to report them to the AMA general counsel's office. The number is (312) 645-4612.

> The caller, claiming to represent a marketing firm, tells physicians that they may have won certain prizes but must purchase personalized calendars in order to receive their prizes. The caller then asks for a credit card account number. Physicians receiving calls have been told that the contest is co-sponsored by the AMA, which is not true. In some cases the callers asked physicians to send in family photographs, which supposedly would be published in American Medical News. That statement also is untrue.

The public rated physicians more ethical than lawyers, business executives, and members of Congress in a Gallup Poll conducted for the Wall Street Journal. Some 53% of the public rated the honesty and ethical standards of medical doctors very high or high; 35% rated them average; and 10% rated them low. Lawyers were rated very high or high by 24%; average by 43%; low by 27%. Congressmen were ranked very high or high by only 14%, while 43% ranked them average and 38% ranked them low.

The percentage of physicians who support advertisement of fees in newspapers or on television or radio has risen from 8% in 1978 to 17% in 1983, an AMA survey reveals. Physician advertising has been noticed by 28% of Americans, according to the survey. Awareness of physician advertising is highest among high income earners (39%) and lowest among those who are 65 years of age and older (17%). The public's awareness of physician advertising has not increased in the last year.

Senator Thad Cochran will address MSMA members and spouses at a banquet on Friday evening, March 2, at the Jackson Regency Hotel. The banquet will precede MSMA's Health Issues Seminar, March 3, during which a panel of speakers will discuss such topics as DRG payment for physician's services, hospital-medical staff conflicts, and the future in Mississippi of HMOs, PPOs, and IPAs. Please mark your calendar now and make plans to attend this important seminar.

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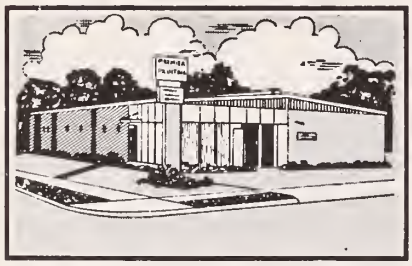

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References:
1. Stone PH, Turi ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm. Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY
PRDCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIDNS AND USAGE: I. Vasospastic Angina: PROCAROIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria. 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCAROIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCAROIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCAROIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCAROIA and a beta blocker, but the possibility that it may occur with PROCAROIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCAROIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCAROIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCAROIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCAROIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCAROIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIDNS: General: Hypotension: Because PROCAROIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCAROIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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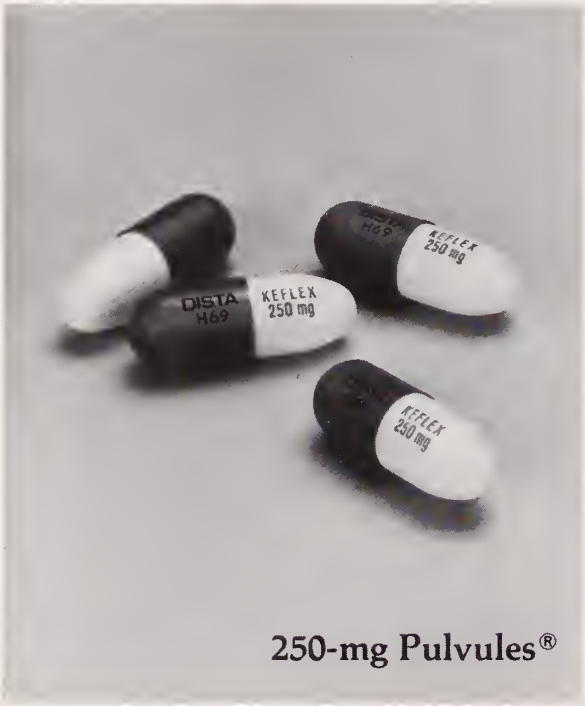

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DATELINE

"Doctors of the Day" Sought for EMCU

Jackson, MS - MSMA will again sponsor the Emergency Medical Care Unit at the Capitol during the 1984 legislative session. During the 120-day session, the unit will be staffed by Mavis Barlow, R.N., and volunteer "Doctors of the Day." As in past years, drug companies will supply medications for the unit, where legislators, staff and Capitol visitors who become ill may be treated. Contact MSMA headquarters to volunteer for "Doctor of the Day" service.

MSMA Submits 1984 Legislative Proposals

Jackson, MS - MSMA's Council on Legislation proposed several items of legislation to be recommended to the 1984 Legislature. The Board of Trustees has approved the Council's recommendations, which include: adequate funding for the Medical Examiner's office; revision of state laws concerning epilepsy; abolition of the insanity defense; amendments to the peer review statute to provide for confidentiality; and increasing the legal age for purchase of alcohol to 21.

Teaching Hospitals Face Problems

Chicago, IL - Some medical schools may close as the result of a national trend to cap the cost of medical care in teaching hospitals, says an AMA Council on Medical Education report. Some hospitals may reduce the number of positions in residency programs. Teaching hospitals face diminishing federal grants to support faculty members, the report notes. Also, competition is creating a decline in income from full-time clinical faculty.

Malpractice Claims More than Doubled

Chicago, IL - The average incidence of malpractice claims during the past five years has more than doubled, according to an AMA report. The number of annual claims per 100 physicians (3.3 before 1978) has jumped to 8. The report identifies the most common physician responses to increasing risk of claims: to keep more detailed patient records (57%), to refer more patients to other physicians (45%), and to prescribe additional diagnostic tests (41%).

Medical Care As Campaign Issue

Chicago, IL - Nearly 80% of physicians believe that medical care issues, especially Medicare, will play an important role in the 1984 presidential campaign, according to an AMA opinion poll. Of the 79% who viewed medical care issues as having some degree of importance, 38% specifically named Medicare as the issue that will dominate the election. The survey also found a diversity of opinion concerning preferences for physician reimbursement methods.

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi, Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties. Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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JOURNAL OF THE MISSISSIPPI MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Treatment of Recurrent Brain Tumors With Intra-Arterial Cis-Platinum and BCNU

JOHN P. KAPP, M.D., Ph.D., and
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Jackson, Mississippi

ALTHOUGH RADIOTHERAPY and systemic chemotherapy have been shown to increase survival time in patients with malignant gliomas, the median survival in the best treatment programs is less than one year.[1] Furthermore, when a treated patient exhibits clinical signs of tumor progression, expected survival is approximately two months both in published reports[2] and unpublished randomized studies of the Southwest Oncology Group. During the past three years we have developed techniques for treatment of malignant gliomas by arterial infusion of chemotherapeutic agents, and during the past 14 months, we have treated seven patients who had recurrent malignant gliomas by combined carotid arterial infusion of cisplatinum and 1-3 bis(2 chloroethyl) nitrosourea (BCNU). Our early success with these patients is the basis of this report.

Methods

Patient Selection. All patients were adults who had malignant astrocytomas or glioblastomas which had recurred following a surgical procedure and radiotherapy. In five of six patients, tumor type was confirmed by biopsy prior to entry into the protocol. In the other two patients, the pathology report from the original craniotomy was accepted. None of the patients had previously received chemotherapy. All patients who presented to the University Medical Center were accepted into the protocol if they consented to treatment after explanation of risks. No patients were excluded because of poor clinical status, age, or large tumor burden.

The authors have developed a technique which delivers the chemotherapeutic agents BCNU and Cis-platinum into the intracranial carotid artery above the origin of the ophthalmic artery, thus sparing the eye from toxicity of the agents. They report results in using the technique in the treatment of malignant glioma.

Drugs. The patients received infusion of cisplatinum 110-200 mg in saline into the supraophthalmic carotid artery over one hour, followed by 300 mg of BCNU in D_5W over 10-15 minutes. The infusion was repeated in two to three months, or when the peripheral blood leucocyte count had returned to at least 4,000 and the platelet count to at least 125,000.

Eight weeks after the second infusion, chloroethyl-cytoclohexyl nitrosourea (CCNU) 100 mg/m^2 was given by mouth and this maintenance therapy was repeated every eight weeks if leucocytes and platelet counts had returned to the levels specified above.

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Supraophthalmic Infusions. The supraophthalmic carotid artery was catheterized with a special flow directed catheter with a tip which was manipulated hydraulically by injecting saline into the cathether. The catheter was inserted through a cutdown into the cervical carotid artery. The procedure was done under general anesthesia. At the conclusion of the infusion the catheter was removed from the carotid artery and the cutdown incision was closed. Systemic heparin was administered prior to catheterization of the carotid artery. The heparin was reversed with protamine after removal of the catheter.

Analysis of Data. End points in our protocol are the response of the tumor to treatment, as determined by its appearance on sequential computed tomographic scans, time interval from first infusion to tumor progression (time to progression) and survival time after first infusion. Of these parameters, change in tumor size, as estimated from CT scans, may be the most dramatic and immediate change. However, measurement of tumor size on CT scans is not totally quantitative since one must allow for differences in quality of scans and slight anatomical differences in the level of the slice. Furthermore, one must consider differences in the volume and intensity of tissue which enhances with contrast, the amount of tissue of low radiographic density surrounding the mass which can either be edematous brain or neoplastic tissue, fluid in tumor cysts, and mass effect as evidenced by ventricular deformity or displacement. Although it is usually clear if the tumor is becoming smaller or larger on sequential scans, the amount of change is only an estimate.

Time to progression is specifically defined in the protocol. Progression of disease is defined as unequivocal deterioration in neurological function unrelated to change in glucocorticoid administration with either increased mass or enhancing tumor on CT scan. We also consider the patient's performance status, utilizing the rating scale of the Southwest Oncology Group (see Table I).

TABLE I
PERFORMANCE STATUS SCALE

0	Fully active, able to carry on all pre-disease activities without restriction. (Karnofsky 90-100)
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g. light house work, office work. (Karnofsky 70-80)
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours. (Karnofsky 30-40)
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours. (Karnofsky 30-40)
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair. (Karnofsky 10-20)
5	Dead.

Results

These data for our evaluable patients are given in Table 2. In one patient (see Figure 1) the tumor completely regressed. In five other patients definite reduction in mass effect and enhancing tumor was noted, and in the seventh patient there was no change in tumor size during a three-month period after infusion. None of the patients have died, with the first patient entered in the protocol surviving at 14 months. Tumor progression has occurred in one patient (CH) who initially had a minimal response to the infusions. In another patient increased enhancement has been seen on the most recent CT scan. Since he has no associated mass effect and especially no clinical deterioration, he is not considered to have progression of disease at this time.

Improvement in performance status has occurred in three patients. Another patient was ambulatory and without neurological impairment prior to entry into the protocol, and remained the same after completion of both drug infusions. In one patient, the tumor has almost completely disappeared (see Figure 2) although her performance status has not appreciably changed. Another patient who had an excellent clinical and radiographic response (see Figure 3) declined further treatment for four months. His neurological status then declined, and CT scan showed that his tumor had grown, although it had not reached its pre-infusion size. He has recently had his second infusion, but sufficient time has not passed to evaluate the result.

Systemic complications of the regimen have been minimal and have not required specific treatment. Severe nausea has been seen for the first one to three days after drug infusion. Reversible nephrotoxicity occurred during the first week, but the worst has been a BUN of 51 mg/dl and serum creatinine of 2.3 mg/dl. Myelosuppression has been apparent at three to four weeks and the bone marrow gradually recovered thereafter. Myelotoxicity was never more severe than grade 2 (mild); specifically, leukocyte counts were not less than 2,000/mm^3. Although we have delayed subsequent courses of therapy because of myelosuppression, platelet and leucocyte transfusion have not been required.

Three of the seven patients developed weakness contralateral to the side of the infusion. In one patient weakness occurred on the first post-infusion day and was associated with hyponatremia. In the

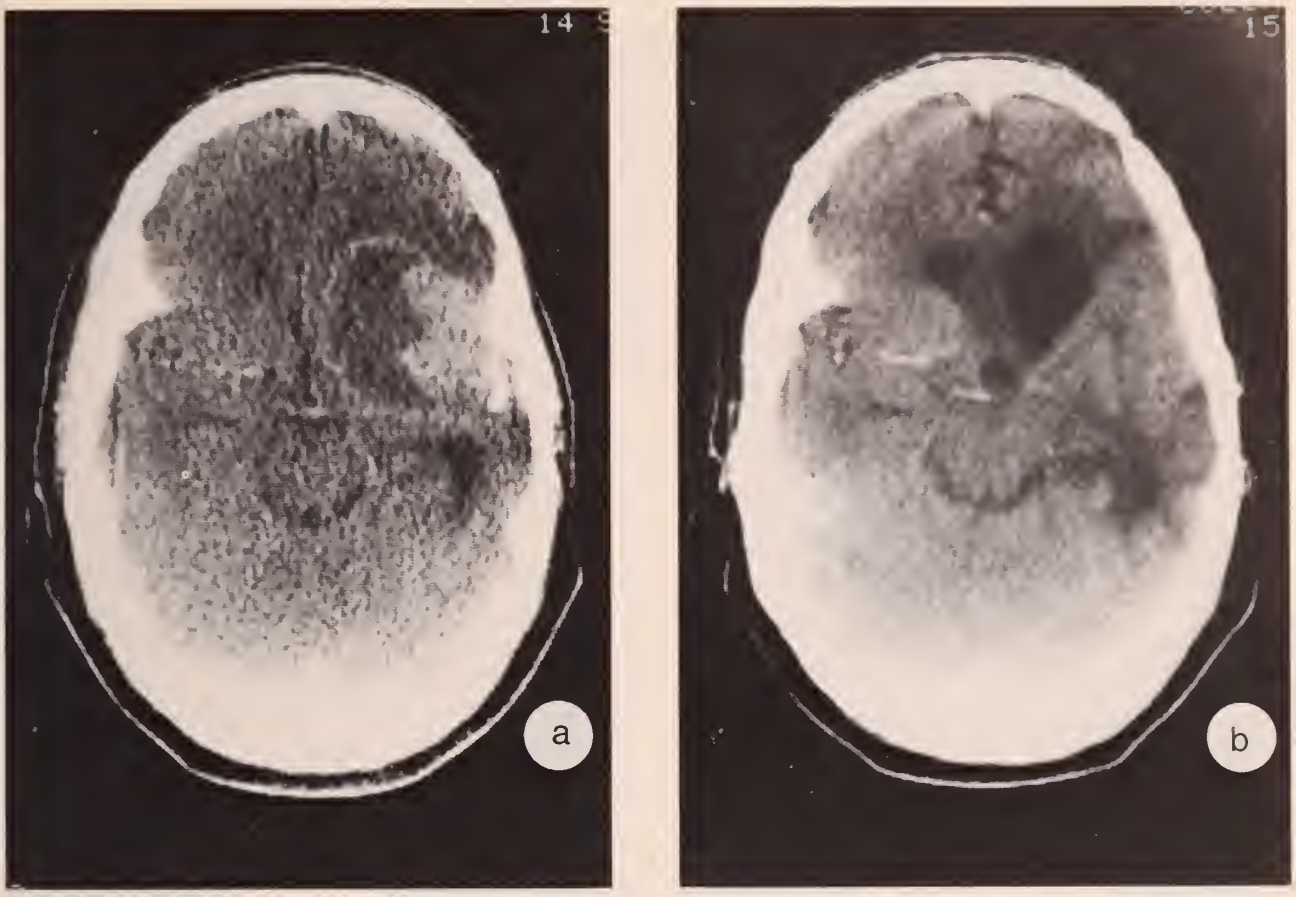

Figure 1. Computed tomographic scans showing glioblastoma multiforme (a) before first infusion, and (b) after two combined infusions of Cisplatinum/BCNU and one course of oral CCNU.

other two patients weakness developed on the third and seventh post-infusion day and was associated with steroid withdrawal. In two of the patients, weakness improved to the pre-infusion level. In the other patient, who was recently infused, weakness has persisted.

There has been no visual loss or other complications related to ocular toxicity of the chemotherapeutic agents, and there have been no complications related to catheterization of the carotid artery.

Discussion

Administration of chemotherapeutic drugs for brain tumor therapy is attractive because the unique anatomical arrangement of the cerebral arterial supply often allows the arterial circulation of the tumor to be isolated and because these neoplasms usually do not metastasize. Thus, systemic toxicity of the drugs can be minimized while still delivering the maximum cytotoxic dose of drug to the tumor that the normal brain can tolerate. Furthermore, in the case of cis-platinum a significant fraction of the drug may be bound to tissue protein during its first pass through the capillary bed.[3] Arterial infusion therefore will deliver greater drug concentration to the tumor with reduced systemic toxicity.

Response rate and complications reported for intracarotid BCNU infusion are directly related to drug dose. Avellanosa et al[4] reported a 40% response rate for gliomas treated with carotid infusion of BCNU at a dose of 100 mg/m^2 with no retinal or brain toxicity. His patients also received systemic vincristine and procarbazine. Using a higher dose of intracarotid BCNU of 250-300 mg/m^2, Greenberg et al reported a 67% response rate. These investigators had a significant incidence of toxicity however, with an incidence of visual loss of 50%.

Feun et al reported a 31% response rate for patients with recurrent gliomas who were treated with intracarotid cis-platinum in a dose of 60-120 mg/m^2. In their entire series, which also included metastatic brain tumor, they reported 14% incidence of retinal toxicity and a 14% incidence of brain toxicity.

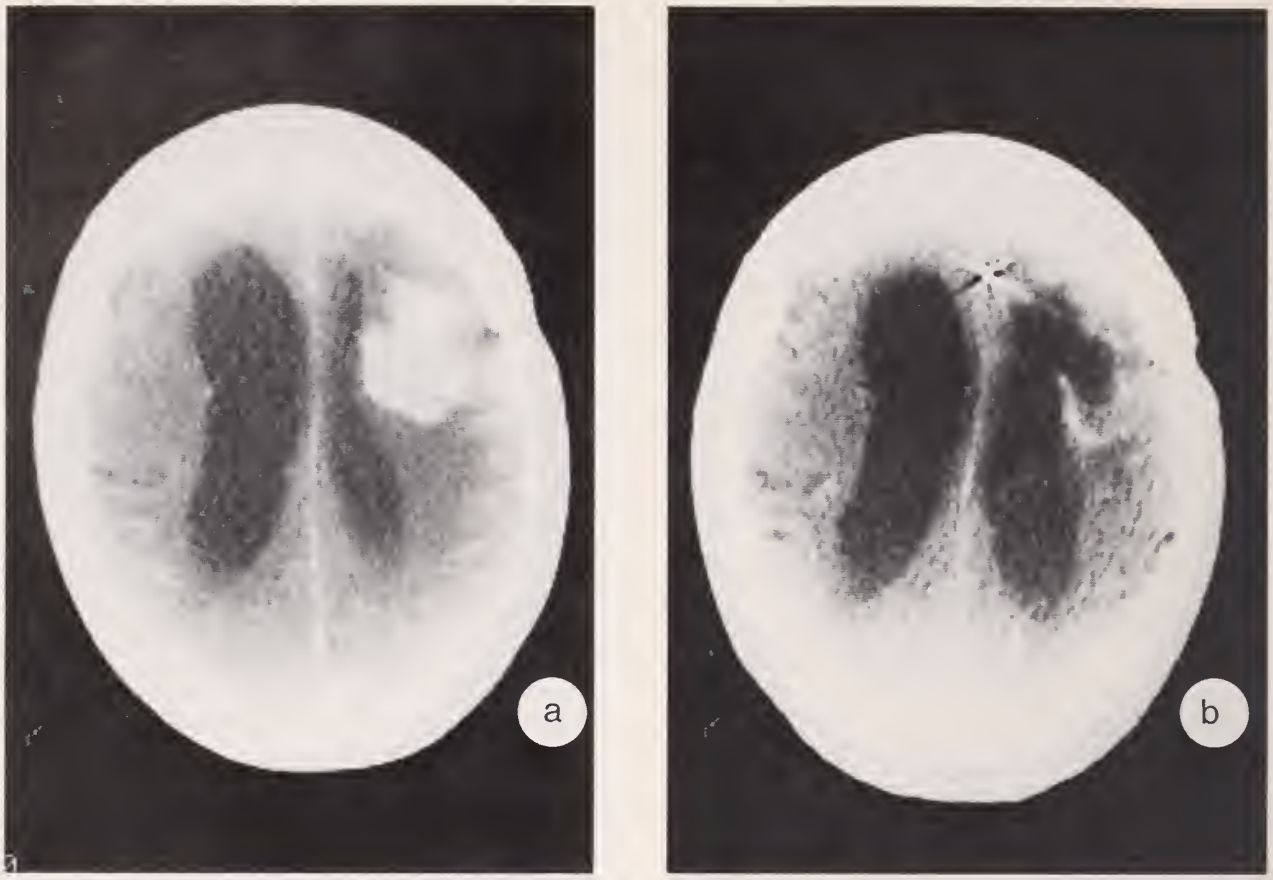

Figure 2. Computed tomographic scan showing malignant astrocytoma (a) before and (b) four months after a single combined Cisplatinum/BCNU infusion.

The combination of cis-platinum and BCNU in an arterial infusion regimen is rational. The major organ toxicities of these drugs are substantially different. The dose limiting toxicity of BCNU is marrow suppression, while the dose of cis-platinum is limited by nephrotoxicity. Although myelosuppression is a side effect of both drugs, the nadirs occur at different times — one to two weeks in the case of cis-platinum and three to four weeks in the case of BCNU.

Finally, the drugs are different in their penetration of the blood brain barrier. Cis-platinum does not cross the intact blood brain barrier in appreciable quantity, while BCNU freely crosses it. Thus the tumor, which has a defective blood brain barrier is exposed to both drugs, while the normal brain with its intact blood brain barrier is relatively protected from exposure to cis-platinum.

Since both drugs are toxic to the eye, one would expect the ocular toxicity of the combination to be unacceptable. We have circumvented this problem by infusing the drug into the intracranial carotid artery above the origin of the ophthalmic artery.[7] The eye then does not receive the high concentration of the drugs during the first pass through the arterial circulation. In these patients, we have had no ocular complications.

Considering the lethal nature of the disease process, our incidence of hemiparesis following the combined drug infusion seems acceptable. In most cases the neurological complications have been transient, and have been related to hyponatremia or to steroid withdrawal.

In the future, variations of drug dose, interval between infusions, and number of infusions may prove to be beneficial, although reduction in drug dosage would be likely to reduce the tumor response. Timing of surgery may be varied, since

TABLE 2

CLINICAL AND RADIOGRAPHIC RESPONSE OF 6 EVALUABLE PATIENTS

Patient	*Tumor*	*Response*	*Number of Infusions*	*Pre-infusion Performance Status*	*Post Infusion Performance Status*	*Survival (months)*	*Time To Progression (months)*
DC	Glioblastoma	100%	2	3	2	14+	No progression
CH	Malignant astrocytoma	25%	2	0	0	7+	Six months
ML	Malignant astrocytoma	95%	1	4	4	4+	No progression
AW	Malignant astrocytoma	40%	2	3	2	8½+	No progression
KG	Malignant astrocytoma	80%	2	4	2	5+	No progression
KE	Malignant astrocytoma	Stable	2	4	4	3+	No progression
SE	Malignant astrocytoma	25%	1	2	3	2+	No progression

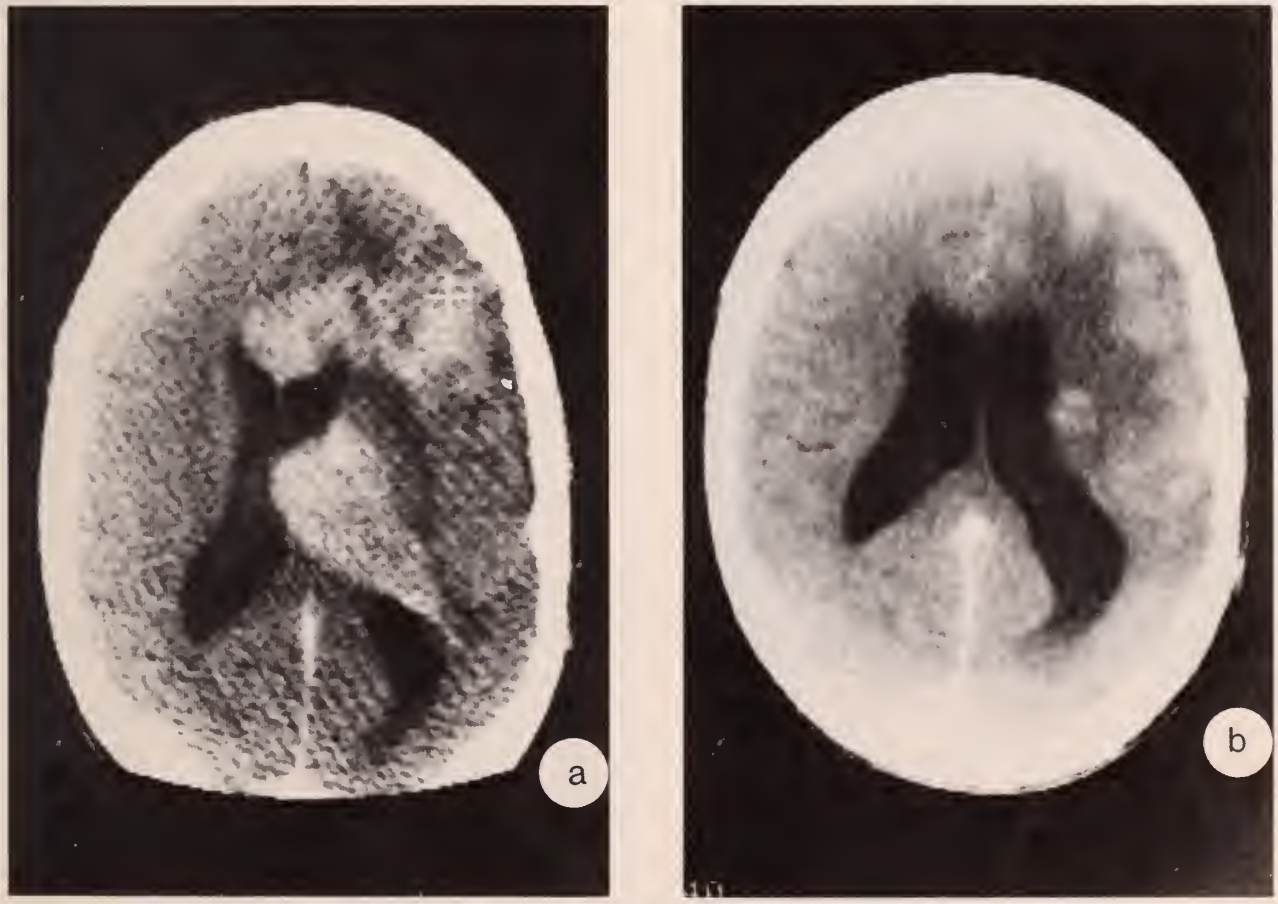

Figure 3. Computed tomographic scan showing malignant astrocytoma (a) before and (b) three months after a single combined Cisplatinum/BCNU infusion.

resection of residual disease after cytoreductive chemotherapy is logical. Resection of accessible residual disease would insure that in many cases no gross tumor was present when maintenance therapy was started, and would provide a population of drug resistant cells for culturing and subsequent drug sensitivity testing. Our laboratory efforts are directed toward developing a drug sensitivity test so that maintenance chemotherapeutic agents can be selected on a rational basis.

Our data, although early, indicate that the radiographic response rate for this method and drug combination for treatment of malignant gliomas is high. Systemic toxicity is minimal and neurotoxicity is acceptable. Survival is greater than one would expect from historical controls, and performance status can be improved in a high percentage of patients.

★★★

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Developmentally Inverted Appendix Presenting as Cecal Polyp: Case Report

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THE DEVELOPMENT of fiberoptic colonoscopy and endoscopic polypectomy has greatly facilitated the management of polyps of the colon. The majority of polypoid lesions of the colon consist of adenomatous polyps, villous adenomas and malignant tumors. The purpose of this report is to describe a case in which the congenitally inverted, but not intussuscepted, appendix presented as a cecal polyp.

Case Report

The patient is a 55-year-old white male, who described a 20 pound weight loss over a three month period. In the course of an evaluation to determine the cause of this weight loss, he underwent an upper GI series which demonstrated chronic changes of peptic ulcer disease. Barium enema was performed, which revealed an abnormal filling defect involving the medial wall of the cecum at the origin of the appendix. The lesion was felt to represent a benign polyp. Fiberoptic colonscopy and endoscopic polypectomy were subsequently performed.

The patient experienced an uneventful recovery following polypectomy. The polyp was recovered and submitted for histological examination. The specimen was described as an inverted appendix, with an outer covering of cecal mucosa, an inner layer of appendiceal mucosa, and submucosal lymphoid follicles. Intussusception was not present.

It is unclear as to what sort of developmental misadventure might result in an inverted appendix. We have been unable to locate other similar cases in the literature in which the appendix is truly inverted without being intussuscepted. This case is presented as a clinical curiosity whose clinical significance is uncertain. ★★★

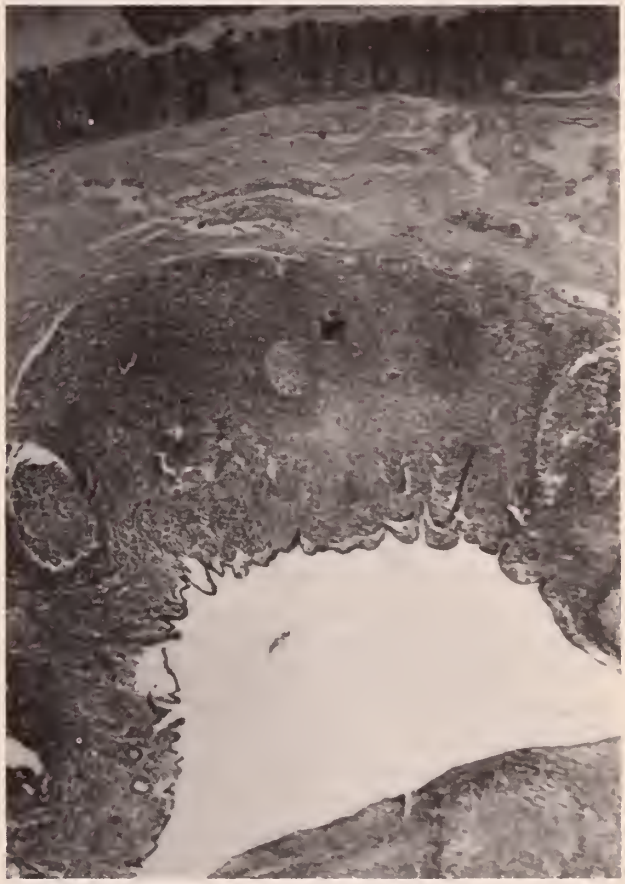

Figure 1. Section of inverted appendix showing colonic mucosa on surface, appendiceal lymphoid tissue and appendiceal mucosa within the lumen.

From the Golden Triangle Regional Medical Center, Columbus, MS.

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Heroics and Heretics: Medical Practice in Antebellum Mississippi

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At the initial meeting of the Mississippi State Medical Society in 1846 Dr. Samuel Cartwright, who served as the first president of the group, lamented the low standards of medical care available in the state at the time. He blamed this unfortunate situation on the "injury done by illy qualified young men being admitted by the scores to practice."[1] On other occasions Cartwright carried his criticism even further. Despite the frightening array of health problems which plagued the Deep South throughout the nineteenth century, he charged, one of the primary causes of "the great mortality of this valley [was] the direct agency of ignorant and empirical practitioners."[2]

Dr. Cartwright's attack on the quality of medical care offered by his contemporaries was well warranted, for there were indeed many who practiced without benefit of even the rudiments of formal education. In fact for almost half a century, between 1836 and 1882, there were no effective legal barriers that could prevent anyone, trained or not, from practicing medicine in Mississippi. But if Cartwright's judgment was correct, his target was misplaced. In criticizing only the uneducated, the doctor overlooked one very important point. Irrespective of the level of training or dedication or skill of the individual physician, the stark reality was that no one in antebellum Mississippi, or for that matter anywhere else in the nation, offered good, beneficial, reliable medical care for the sick. No one was aware of the scientific principles upon which modern medicine is based. No one comprehended either the causes, the course, or the nature of the diseases and disorders they treated. Practitioners of every caliber approached their patients with therapeutics which bore no real relationship to the problems they confronted, therapeutics which often produced more harm than good. "Imperfectly educated and illy qualified young men" may, as Cartwright claimed, have done great injury, but so did those who were well educated and well qualified by nineteenth century standards.

Typical Medical Problems

To understand medicine as it was practiced in antebellum America it is necessary first to appreciate the seriousness of the myriad medical problems that faced the people of that day and then to recognize the inability of the medical profession to cope with those problems. For Mississippi's first citizens life was precarious at best. The frontier conditions and what one physician described as the "inhospitable clime"[3] of this semi-tropical region brought frequent illness and the omnipresent threat of premature death to early settlers. They often found themselves over-exposed to the elements and subject to the severe respiratory diseases which were the nation's foremost killers in the nineteenth century. Nutritional inadequacies left many chronically debilitated, while contaminated food and water produced such further complications as developmental disorders and intestinal diseases. The marshy river lowlands were such a receptive breeding place for mosquitoes that malaria came to be accepted as a matter of course. In addition to these common and usually unavoidable distresses, inhabitants of the region were visited periodically with dreadful epidemic diseases which were brought in by travelers, usually from the river. Smallpox invaded antebellum Mississippi on several occasions, as did the "devastating pestilence" Asiatic cholera and the more frequent but equally frightening yellow fever.[4] In the few towns that developed as the area became more populous, close living quarters presented other dangers because of the absence of any public sanitation and the recurrence of such serious contagious diseases as diphtheria, scarlet fever, and measles.

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Medical Knowledge

The level of medical knowledge and the competency of the medical profession did little to ameliorate this situation. It is important to remember that what any school child of today knows about bacteria and viruses was a mystery to the best minds of the early nineteenth century. By then European researchers had begun to make great strides in understanding such basic biological sciences as anatomy and physiology. But little was known about the source and nature of infectious and contagious disease. Moreover, most practitioners lagged far behind the pure scientist, especially in the South where the lack of transportation and the scarcity of major urban areas hindered the dissemination of knowledge. Even as Mississippi began to move into the modern world with its democratic political institutions and such technological marvels as the railroad, the practice of medicine remained closer to Medieval Europe than to twentieth century America. Throughout the antebellum period the age-old diseases and disorders that had plagued mankind since time immemorial continued to move unabated through the Southland with discouraging regularity, while men still looked for causes in all the wrong places.

During the formative years of the American Republic there did not exist anywhere, either in the respected European universities or on the frontier of the Old South, a substantial body of useful and accurate medical information. As a result physicians relied for diagnosis and treatment not on the certainty of knowledge but instead on the probability of theory. For the most part, however, their theories were more metaphysical than scientific. Many well-trained medical men perceived the etiology of all disease to lie in one fundamental biological principle. The giant of eighteenth century American medicine, Benjamin Rush, the signer of the Declaration of Independence who was often called the American Hippocrates, reinforced this belief in a monistic pathology by maintaining that the underlying cause of all illness was vascular tension.[5]

Because the theories of Rush and others held no medical validity, few medically valid therapies could be derived from them. The treatment of diseases was based on conjecture rather than accurate diagnosis and proven remedies. Most physicians subscribed to the position that if disease derived from one fundamental source, all maladies could be cured with similar panaceas. Accordingly physicians believed the proper treatment for almost all illnesses to consist of several routine steps, most of which succeeded only in inducing quick alterations in external symptoms.

Foremost among these steps was bloodletting, an antiphlogistic procedure which caused fever to pass and was applied for everything from cholera to burns to fractures. Equally important was a thorough cleansing of the body brought about through the administration of powerful chemical purgatives and emetics. Drugs, including both mineral and botanical compounds, were also frequently used. Skin irritants were applied externally to raise blisters and release harmful matter from the body through the flow of pus, while heating remedies accomplished the same end through sweating. These measures were often supplemented with a variety of restorative tonics, including quinine, one of the few medications at this time which was truly effective, especially in the treatment of malaria.[6] Though such "heroic medicine," as these tactics were labeled, was in and of itself quite drastic, making it even more dramatic was the excessive manner in which these procedures were carried out. As Rush argued, "desperate diseases require desperate remedies."[7] Bleeding, for instance, might involve drawing as much as 50 ounces of blood from the body. The drug calomel, which is a chloride of mercury, was a widely accepted cathartic which was often given in doses massive enough to be lethal over a period of time.

There is abundant evidence that Mississippi physicians, regardless of their level of training, applied all these tactics. When Asiatic cholera first swept through the state in 1833, one Dr. Cannon recommended that victims be treated with an ointment made of nitric acid, quicksilver, lard, sweet oil, and camphor.[8] Other suggestions included first "a vomit of salt and water" or the emetic ipecac, next 60 grains of calomel every hour for three or four hours, then castor oil, and finally injections of spirits of turpentine.[9] When cholera struck again in 1849, patients were treated with "heating" medicines such as cayenne pepper, camphor, and peppermint to bring on sweating and then with calomel to unlock the liver so that the bile could flow. These oral medications were followed by a "hot mustard foot bath, hot bricks to the feet, large plasters of mustard over the abdomen, and thighs and legs." Next came bloodletting, provided the skin was still warm and the pulse firm. The treatment was topped off with a "brandy toddy" or, as planter-physician Martin W. Phillips preferred, a dose of opium.[10]

There was, to be sure, a lack of complete agreement over the benefits of heroic medicine. Surprisingly, enough patients survived these treatments for even intelligent men to extol the benefits. One prose-

lyte told of a "dying, cold as ice, pulseless and speechless" man who "jumped up and was walking about" within a half hour after he had received calomel in 100 grain doses.[11] A reviewer in the *Western Journal of Medicine and Physical Science* praised the "great boldness and energy" of the medical practitioners of the lower Mississippi Valley, who relied on the lancet and calomel as their "anchor of hope."[12]

Dissent Among Practitioners

A number of skeptics, however, quarreled with these drastic measures, urging moderation if not abandonment of such drugs and tactics. Dissent among the mainstream of medical practitioners, in turn, illustrated to a wary public the uncertainty and the limitations of the professionals to whom they entrusted their lives. Coupled with the obvious dangers and shortcomings of the therapeutics and theories of heroic medicine, these doubts led many in the antebellum South, as elsewhere in the country, to reject the orthodox physician. Despite the persistence of heroic practices, as the century wore on more and more Americans turned to the potions and programs hawked by a host of medical imposters and sectarians who sprang up throughout the rapidly growing nation to offer alternative solutions to the recurring maladies that threatened the population.

To understand the willingness of the American public to buy into these "quack" solutions, it is necessary to keep several factors in mind, including the traditional gullibility of the general public and the natural workings of the free enterprise system. The idea of a quick fix, rational or not, still appeals to those who demand an easy solution for every problem. But more importantly, the helplessness of nineteenth century man in the face of dangerous disease rendered him particularly susceptible to the medical con man. Confronted with continuously irritating and periodically devastating health problems, people were willing to try almost anything. On a daily basis concern with health occupied private thoughts. In the face of epidemic, concern for health became a matter of public urgency.

It is quite difficult to imagine a disaster short of earthquake or war that would in today's sterilized, painless world disrupt social, economic, political, and private life so thoroughly as did the major epidemics that moved frequently and freely through antebellum America. Every facet of life was affected. Panic was the order of the day. Families that could afford to do so uprooted in search of more salubrious locations. Newspapers warned those who remained to take preventive action and published advice concerning remedial measures. Officials attempted to impose quarantines. Public life literally came to a halt. The government of the state either shut down or moved from the capital to a safer site. As late as 1897 the University of Mississippi remained closed for the first two months of the academic year because of the presence of yellow fever in the region, only to discover reduced enrollment when the school finally opened.[13] Financial losses created widespread economic hardship in the wake of epidemics, for businesses were forced to curtail their operations, productive activity was sharply reduced because of illness, and lives were lost. In the cholera epidemic of 1849, Dr. Stephen Duncan of Natchez, a planter who was also a physician and thus should have been more able than most to cope with the disaster, lost 133 field hands and his entire cotton crop for the year. Other planters lost up to two-thirds of their slaves.[14] Such a heavy toll in no way indicates that slaves were medically deprived, for they usually received the same caliber of care as their white owners, but instead underscores the impotence of men in the face of disease.

Development of Medical Sects

The obvious need for medical help in antebellum America and the inability of the orthodox doctors to provide that help encouraged the development of a variety of medical sects. The rise of these sectarians, who were bitterly resented and scorned by the regulars, was one important reason why this period is often termed the Dark Ages of American Medicine. But in all fairness it must be remembered that their various programs, which often advocated clean, healthy living and natural remedies, were scarcely more injurious to the patient than heroic medicine. No doubt these sects would not have been so popular had not the general public so distrusted the medical profession as a whole.[15] Of these sects there were three that gained particular prominence in Mississippi: homeopathy, Thomsonianism, and hydropathy.

Homeopathy, a theory developed by the German Dr. Samuel Hahnemann, was predicated on the assumption that whatever substance induced the symptoms of a disease would also cure that disease if administered in infinitesimally small doses. Eventually adherents to this theory became so influential that they established separate hospitals and a national medical organization. On into the twentieth century they continued to compete rather successfully with the regulars. Since thair tactics in effect allowed nature to cure the diseased, their methods oftentimes produced successful results.[16] Consequently homeopathy attracted to its folds a number

of educated physicians who were disillusioned with heroics.

In Mississippi homeopathy was adopted by two Natchez physicians. Dr. William Holcombe began his practice of medicine by working with Dr. F. A. W. Davis, a trained physician who had been converted to homeopathy. During the yellow fever outbreak of 1853 Holcombe and Davis, using homeopathic therapy, claimed that they lost only 33 patients as opposed to 430 deaths among the patients of the city's orthodox practitioners. The two homeopaths subsequently received substantial public support and were placed in charge of the Mississippi State Hospital in Natchez in January 1854, where they sharply reduced the death rate by forbidding the use of "bleeding, purgatives, calomel, blisters, and other allopathic measures."[17]

Another important sectarian group were the Thomsonians, who had become popular enough by 1835 for the governor of Mississippi to proclaim that half the state supported the Thomson system.[18] Founded by the self-taught Samuel Thomson, this system was loudly touted as being more effective, more convenient, and less expensive than orthodox medicine. Thomsonians advocated that health problems be treated with botanical remedies and steam baths. They also championed the cause of sound dietetic practices and preached against the evils of alcohol. In this respect they reflected the reform spirit of the time, especially the temperance crusade, and also illustrated the widely held belief that disease was associated with sin.[19]

Thomsonianism swept rapidly through rural antebellum America as disciples spread the word, circulating Thompson's *New Guide to Health,* lecturing in public forums on the benefits of the system, prescribing Thomson's compounds, and selling Family Rights to the patented program. Unlike homeopaths, who were often trained professionals, Thomsonians preached the gospel of self-help. They rejected the need for medical doctors and medical schools, arguing that people should be allowed to treat themselves. Thomsonianism allowed women, considered to be superior nurturers and caretakers by virtue of their sex, to practice family medical care and encouraged the male head of every American family to "in medicine, as in religion and politics, think and act for himself."[20]

A third sect grew around the theory of hydropathy, which relied on the curative properties of "pure" or mineral water used both externally and internally. Also extolling the benefits of fresh air, sunshine, exercise, and proper diet, this program was particularly popular on the Mississippi Gulf Coast. There, "watering places," promising social and recreational as well as medicinal advantages, lured many visitors. A variety of resorts offered "valuable mineral springs" which would afford the patron a "remarkable recovery from the extremest cases of debility and sickness."[21]

Indicative of the response of Mississippians to hydropathy were the two sisters who were treated by a Dr. Byrenheidt at his institute in Biloxi. One of these young ladies, Kitty Hamilton, praised the doctor's "delicacy and consideration for female modesty."[22] Her sister Penelope lamented the "hours of pain and anguish" which had befallen her under the care of "pillgivers," who had "butchered" her with their "poisonous drugs." Dr. Byrendheidt, she gladly reported, prescribed no drugs, only cold water and exercise.[23] Little wonder that such a natural, hygenic regimen would be more helpful and popular in treating health complaints than the technique of bleeding or the administration of drugs like mercury!

The "pillgivers" and their "poisonous drugs" of which Miss Hamilton spoke were visible in every quarter of the nation throughout the antebellum period, and not just from the medical profession. Family and folk remedies were patented, widely advertised in the vocal and influential newspapers of the day, and peddled in traveling medicine shows. In Mississippi a variety of panaceas and elixirs, the alcoholic content of which often far surpassed any healing virtue, guaranteed to treat, often simultaneously, such diverse disorders as venereal disease, freckles, cholera, rabies, baldness, leprosy, and kidney disease. The most confident of these promised "no cure no pay."[24] For those who preferred a more traditional remedy, a supply of "the best imported Leeches" could be purchased from time to time.[25] Surgical instruments and medical books, including instructions for amputations, were also for sale to the general public. The availability of these home remedies, together with the appeal of the sectarians, presented the orthodox physicians with competition stiff enough to prompt them to employ a practice that is today quite controversial. Hardly a newspaper was published that did not include several advertisements in which ambitious doctors, often designating hotel or boarding house rooms as their offices, boasted of their credentials and claimed the ability to cure any disease. They even assured the public of their willingness to make house calls, especially for female patients.[26]

Emergence of Modern Medicine

Such exaggerated claims and accommodating

spirits could not, however, compensate for the basic dilemma that faced antebellum physicians. The rivalry represented by home medications, sectarians, and quack remedies would have fallen on deaf ears had not the public recognized the inadequacy of the trained, orthodox physicians. By the late antebellum period both state and national medical associations had been created for the specific purpose of ridding the profession of quacks and upgrading the general standards of the profession, as Dr. Cartwright had proposed. But real respectability, confidence, and financial security would come to physicians only when they abandoned heroics for modern scientific therapeutics in the late nineteenth century.

The beginnings of what was to become the bacteriological revolution had begun to stir in Europe even before the American Civil War, but for the most part these innovations were still in the experimental stages in the antebellum period, understood by few and employed by fewer. The state of the art was not noteworthy when the war broke out. The guns of Fort Sumter shattered forever the social, political, and economic structure of the Old South and cleared the path for the emergence of modern America. Coinciding chronologically with great advances in science, the four-year ordeal of the nation also opened the door for the emergence of modern medicine. After the war the heroics and heretics that had been the hallmarks of antebellum medicine gave way, albeit slowly, as the progress of science brought a new type of practitioner, new standards of medical education, new licensure requirements, and high quality modern medicine to Mississippi. ★★★

3591 Bridgforth Road (38654)

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The President Speaking

The Way Things Were

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

In any presidential election year, the inevitable question is, "Are you better off now than you were then?" Let's take a nostalgic look back to January, 1974 and 1964, to see how things were then and compare with the present.

January 1964 found the nation having had three years of prosperity under the recently assassinated popular president, John F. Kennedy. A first class mail stamp had just been raised to 5 cents. A new Chevrolet with radio and air-conditioning could be bought for $2,245 or a Cadillac for less than $5,000; and they ran on gas for 26 cents a gallon. A new three bedroom, two bathroom home in the prime residential area could be purchased for $13,200 on a bank loan at 4.5% interest. You could bring home the bacon for 59 cents per pound, ham was 29 cents, or you could eat sirloin steak for 79 cents or T-bone for 89 cents per pound. Basic $100,000/$300,000 was more than enough protection. For a surgeon, an occurrence made policy cost $217 yearly. An L.P.N. could be hired for $1.04 per hour and an R.N. worked for $1.95. The inflation rate was 1.4% and unemployment was 4.2%. There was no Medicare, Medicaid, or food stamps, although that month the federal government passed out 9,129,821 pounds or $2,104,000 in surplus food in Mississippi. In opinion polls, physicians were far and away the most respected profession or career endeavor, and we received 21% of the total monies spent on health care.

By January 1974, the winds of change had blown some clouds on the American scene. In the past few months, Vice President Agnew had been removed from office and replaced by Gerald Ford. Ford had been appointed by President Nixon, who was in hot water, set to a boil by the Watergate affair as well as campaign contribution irregularities. The public was becoming mistrustful not only of their elected officials, but also of everything else. Government bureacracy and regulations had become an everyday fact of life. First class mail then cost 10 cents per letter or bill. A new Impala sold for $3,695 and a Lincoln Continental, $9,200. The oil embargo was in full swing, but gasoline cost 66 cents a gallon. The same new home as described above went for $26,300. Bacon sold for 88 cents per pound; sirloin steak was $1.59 and T-bone, $1.69 per pound. A million dollar umbrella had become

(continued on page 16)

EDITORIALS

JOURNAL OF THE
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Cordless Telephones — A Public Health Hazard

Recent changes in regulations controlling the telephone communications industry led to the production and distribution of portable or cordless telephones. The truly portable telephone performs all of the functions of the ordinary telephone while operating independently of a base unit or station, as long as the portable unit is within a specified distance from the base unit. They do, however, differ from the ordinary telephone in several very important ways. Lifting the handpiece from the cradle of an ordinary telephone activates switches. This disables the ringer and connects the unit to the phone line. Portable units utilize electronic noises as a substitute for the bell ringer; and to conserve space and reduce cost, the speaker, or earpiece, of the portable unit substitutes as the ringing unit. These units also contain a switch that must be activated before the phone can be used. This switch serves the same function as the cradle switch on the ordinary phone, disabling the ringer and activating the line.

Being creatures of habit, people are accustomed to answering a telephone without having to first flip a switch on the handpiece. This has led to a significant problem for users of portable units. Upon ringing, the unit is picked up and spontaneously placed against the ear. About the time the handpiece is placed firmly against the ear, it rings again, producing a very painful and sometimes damaging noise to the ear. Cases of documented permanent neurosensory hearing loss resulting from use of the cordless telephones have been reported. The number of cases of such hearing loss appears to be rapidly increasing.

Studies conducted on several portable units showed an average of 140 decible sound pressure level at the frequency of 700 and 1000 Hz.

With approximately three million portable telephones being placed into service in this country over the past two years, a significant potential public health hazard exists. At this time, the American Academy of Otolaryngology — Head and Neck Surgery is studying this matter and has suggested that manufacturers modify the equipment to employ a ringer isolated from the earpiece. Until such modifications become mandatory, physicians should be alert for complaints of painful tinnitus, hyperacusis, severe headaches, and neurosensory hearing loss associated with the use of these units. In addition, when possible, patients should be warned of the potential hazard associated with the use of portable telephones.

MYRON W. LOCKEY, M.D.
Editor

LETTERS

Dear DR. JOHNSTON: At a recent meeting the Council of the Mississippi Eye, Ear, Nose and Throat Association discussed your editorial, "That Competitive Edge," which appeared in the November 1983 issue of the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION.

We want to commend you on an outstanding editorial and let you know that we agree with you and support your position.

Our association is deeply concerned about the encroachment of non-medical practitioners into the field of medicine. We have had and will continue to have bitter legislative fights because we believe that, to practice medicine, a person should have a medical education.

For a long time, it seemed that we were a voice crying in the wilderness. Fortunately, however, it

appears that other specialties are beginning to wake up to what is happening.

More community involvement on the part of physicians is definitely needed and we'll continue to encourage our members.

Thank you for taking time to prepare an outstanding editorial.

William C. Mayfield, M.D.
President,
Miss. EENT Association
Jackson, MS

The President Speaking

(continued from page 14)

necessary for malpractice insurance; and although the occurrence made policy was still common, it cost a surgeon $1,800. Office help was more expensive with an L.P.N. making $2.78, and an R.N., $4.04 per hour. By that time, most physicians felt it necessary to enroll their children in private schools to the tune of $600 per child per year plus a percent of their annual income. Medicare, Medicaid, and food stamps were causing changes in the marketplace by increasing the demand for services and goods without increasing the supply. The inflation rate had risen to 9.1%, unemployment was 5.1%, and the minimum wage had been elevated to $2.00 per hour. By public opinion polls, physicians had slipped but were still in first place; and our slice of the health care pie had been reduced to 19%.

Well, that's the way things were, so you can look around and compare them with the way things are now. Realize also that we just survived a near miss in Congress on mandatory assignment of Medicare benefits as full pay, with criminal penalties for failure to comply, and that every time the government passes out sheckles, shackles accompany them. Let us not lose so much of our independence by becoming so government and third-party dependent that we forget our primary duty is to the patient and slip in the polls to the level of a used car salesman. ★★★

JOIN MPAC TODAY

Medico-Legal Brief

MD's Partners Liable For His Negligence

The partners of a deceased physician were liable for $375,000 in damages for his negligent treatment of a patient, the highest court of Massachusetts ruled.

The physician practiced medicine with several other physicians in 1959, when he operated on the patient for cancer of the rectum. In 1962, the physicians formed a partnership. In July 1969, the patient returned to the physician complaining of severe pain. He performed two operations — one for a twisted bowel and one for adhesions. A single Penrose drain was inserted during one of the operations.

Two months later the patient came back to the physician with an abscess in his perineum, which the physician drained. The drainage persisted and he tried to cauterize the abscess with a silver nitrate stick. He told the patient that those problems often take a long time to go away. On January 1, 1970, the partnership was ended and a corporation succeeded it. The patient saw the physician several times during the first half of 1970.

The abscess continued to drain during the next several years, causing a substantial unpleasant odor and considerable discomfort. In 1978, another physician performed a sinogram. The perineal sinus was explored, part of the patient's coccyx was removed, and a Penrose drain was found above the sinus tract and in front of the coccyx.

The treating physician died in 1975, and the patient filed suit against the nine physicians who were his partners. A trial court returned a verdict of $375,000 in favor of the patient and the physicians appealed.

On appeal, the court said that the evidence was sufficient to show that a partnership existed. There was testimony that the patient received joint bills, that a certificate filed with the city clerk was signed by all ten physicians, that they insured their liability as partners, and that certain of the physicians stated that they were partners.

The evidence was sufficient to find the physician negligent for failing to remove the Penrose drain and delaying in taking action to correct the cause of the drainage. The trial court's decision was affirmed. — *Van Dyke v. Bixby,* 448 N.E.2d 353 (Mass.Sup. Jud.Ct., April 8, 1983)

Board of Trustees Holds Fall Meeting

MSMA's Board of Trustees held its regular fall meeting in Jackson on December 1 and handled an extensive agenda to include review and approval of the association's 1984 legislative recommendations and the annual MSMA budget.

The association will recommend a five point health legislation program to include: (1) funding for the Statewide Medical Examiner's System; (2) improved confidentiality requirements for peer review; (3) raising the legal age for purchase of alcohol to 21 years; (4) revision of statutes dealing with epilepsy; and (5) abolishing insanity as a defense in criminal cases. The association will also monitor budgetary requirements for Medicaid and other health programs to seek adequate funding for these programs in light of expected financial restraints facing the 1984 legislative session.

The Board also reviewed recommendations from the association's Council on Budget and Finance dealing with the 1984 budget. A 1984 budget of $1,473,000 was approved for MSMA and MSMA Services, Inc., to include an expected $495,000 in AMA dues payments.

In other activities the Board reviewed plans for MSMA to serve as statewide distributor of the GTE (AMA) Telenet Medical Information Network. The program will be publicized to the membership with particular emphasis being made to those members using computer systems at this time.

The Board also acted to implement a plan for consideration of an MSMA building program and heard status reports on operation of the MSMA Benefit Plan and Trust, JCAH requirements for hospital medical staffs, operation of emergency medical clinics, State Department of Health activities, development of a brochure on breast cancer, and the MSMA CommuniCare Program.

The Board also reviewed plans for the 1984 MSMA Health Issues Seminar to be conducted in Jackson on March 3, beginning with a banquet on March 2 featuring Senator Thad Cochran.

Board members and officers attending the December 1 meeting included: J. O. Manning, M.D., chairman, Jackson; W. Joseph Burnett, M.D., vice chairman, Oxford; Roy D. Duncan, M.D., secre-

Members of the MSMA Board of Trustees at Fall Meeting in Jackson.

BOARD OF TRUSTEES / Continued

tary, Pascagoula; Virginia S. Tolbert, M.D., Ruleville; William C. Gates, M.D., Columbus; William B. Hunt, M.D., Grenada; C. G. Sutherland, M.D., Jackson; W. Boyce White, M.D., Laurel; David R. Steckler, M.D., Natchez; Whitman B. Johnson, Jr., M.D., president, Clarksdale; Ellis M. Moffit, M.D., president-elect, Jackson; Sidney O. Graves, Jr., M.D., immediate past president, Natchez; J. Elmer Nix, M.D., secretary-treasurer, Jackson; Carl G. Evers, M.D., speaker of the House, Jackson; James C. Waites, M.D., vice speaker of the House, Laurel; James O. Gilmore, M.D., delegate to AMA, Oxford; and W. Lamar Weems, M.D., Jackson, delegate to AMA.

Dr. Guy T. Vise, Sr. Announces Retirement

Dr. Guy T. Vise, Sr., of Meridian concluded 50 years of medical practice when he retired on November 15.

"It's always been a great, challenging and interesting life," said the former MSMA president in an interview with the *Meridian Star*. "There has never been a dull day," he added, noting that the practice of medicine had been one of the greatest joys of his life. He had wanted to be a physician, he said, since he was 12 years old.

Retirement won't mean inactivity, he indicated, announcing his plans to travel and pursue his longtime hobby, tree farming.

In addition to serving as MSMA president, Dr. Vise was also chairman of the MSMA Board of Trustees. He served as president of Southern Medical Association and the Mississippi Academy of General Practice. Throughout his career he was active in professional, civic and community organizations. For many years he has been an Elder in the First Presbyterian Church of Meridian.

Dr. Vise and his wife have five children, three of who are physicians: Dr. Guy T. Vise, Jr., and Dr. W. Michael Vise, both of Jackson, and Dr. Richard M. Vise of Meridian.

MSMA Board of Trustees held its annual Fall Meeting in December.

UMC Hosts Annual Pediatric Conference

Dr. Robert Abney (right), clinical instructor in pediatrics at the University of Mississippi Medical Center, was course coordinator for the annual meeting of the Mississippi Chapter of the American Academy of Pediatrics, of which he is president. Program sponsors were the UMC School of Medicine Department of Pediatrics and the UMC Division of Continuing Health Professional Education. Guest speakers were Dr. Robert E. Merrill, professor of pediatrics at Southern Illinois School of Medicine in Springfield, and Dr. Floyd Denny, professor of pediatrics at the University of North Carolina School of Medicine. Pictured also are participants Dr. Robert Buckley (left) of Columbus and Dr. William Simmons of Meridian.

Renal Update Seminar Scheduled in Jackson

The University of Mississippi Medical Center annual renal update program is set for Friday, February 3, at the Sheraton Regency Convention Center in Jackson.

The program is designed to give the practicing physician the most current information on the prevention and treatment of renal failure and address questions encountered in the clinical management of nephrologic problems. Topics will include controlling the complications of diabetes, a leading cause of chronic renal failure; examining the efficacy of low protein diets in delaying chronic renal failure; identifying nephrotoxic agents that may induce renal impairment; and an examination of diuretics, antihypertensives, plasmapheresis, the newest method of peritoneal dialysis and the impact of the new immunosuppressive agent Cyclosporin A on kidney transplantation.

Course coordinator is Dr. John D. Bower, UMC professor of medicine (nephrology), assistant professor of physiology-biophysics, and director of the artificial kidney unit at University Hospital.

Joining UMC faculty speakers are guest speakers Dr. Eli A. Friedman, professor of medicine at Downstate Medical Center and consultant at Veterans' Administration Hospital, Brooklyn, N. Y., and Dr. Karl W. Hatten, in private practice in Vicksburg.

The seminar is sponsored by the UMC School of Medicine Departments of Medicine and Family Medicine and the UMC Division of Continuing Professional Education, in cooperation with Kidney Care, Inc., the Kidney Foundation of Mississippi, the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Registration fee for the course is $55. The American Medical Association will award 7 credit hours in Category I of the Physicians' Recognition Award, and the American Academy of Family Physicians will award 7 prescribed hours.

For further information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone 987-4914.

NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

PERSONALS

Vinod Anand of UMC presented a paper at the Association of Sleep Disorders Centers meeting in Anaheim, California.

Art Applewhite announces the opening of his office for the general practice of medicine at 300 Rawls Drive, Suite 900, in McComb.

Robert Davis of Corinth has been named chief of staff of Magnolia Hospital.

Carl Evers of UMC presented a site visit report in Denver, Colorado, recently, and was speaker for the Columbus Rotary Club in Columbus.

Lionel B. Fraser, Jr., announces the opening of his office for the practice of adult and pediatric urology at Suite 104, 2969 University Drive in Jackson.

John Gibson of UMC presented a paper at the recent Southern Medical Association annual meeting in Baltimore.

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Wilfred Gillis of UMC attended the Washington, D. C., meeting of the Association of Departments of Family Medicine as program chairman.

James Hardy of UMC gave the Emmett B. Frazer Lecture at the University of South Alabama in Mobile in November.

Glyn R. Hilbun of Pascagoula has been named chief of staff at Singing River Hospital. Other officers are Thomas R. Singley, chief of staff-elect, and Harris G. Barrett, secretary-treasurer.

Herbert Langford of UMC presented a paper at the International Forum for Nutritional Prevention of Cardiovascular Disease in Kyoto, Japan, recently.

Norman Nelson was visiting professor at the Lafayette General Hospital in Lafayette, Louisiana.

William Nicholas of UMC was guest speaker at the annual Refresher Course for Practicing Physicians at Dalhousie University in Halifax, Nova Scotia, Canada, in November.

Ramesh Patel of UMC presented a paper at the annual meeting of Southern Medical Association in Baltimore.

John B. Russell announces the opening of his office for the practice of family medicine in the clinic of Community Hospital of Calhoun County.

David G. Skagerberg announces the opening of his practice in office orthopaedics and disability evaluations at 1213 Broad Avenue in Gulfport.

Thomas L. Sweat of Corinth has been named chairman of the board of trustees of Magnolia Hospital.

John Tanksley of Tupelo attended the Scoliosis Research Society meeting in New Orleans. A paper on occult spinal lesions in children, which he coauthored, was presented at the meeting.

Nancy O'Neal Tatum of Petal has been named a diplomate of the American Board of Family Practice.

F. E. Thompson of Jackson was guest speaker at a recent meeting of the Brookhaven Lions Club.

Lamar Weems of UMC presented a paper and moderated a session at the recent meeting in Philadelphia, Pennsylvania, of the Society of Pelvic Surgeons. He also spoke to the Philadelphia Urological Society and was visiting professor at Temple University.

John E. Williams has been named chief of staff of the Outpatient Surgical Center. Barbara A. Bolling is chief of staff elect.

POSTGRADUATE CALENDAR

March 15-17
SURGICAL FORUM XI
Holiday Inn Downtown, Jackson

April 4-6
1984 FAMILY PRACTICE UPDATE
Holiday Inn Downtown, Jackson

June 7-8
SIXTH ANNUAL NEUROLOGY SPRING SYMPOSIUM
Holiday Inn Medical Center, Jackson

Aug. 18
OPHTHALMOLOGY UPDATE, 1984
Holiday Inn Downtown, Jackson

For more information on continuing education, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39126. Phone (601) 987-4914.

BOOK REVIEW

***Tomatoes in the Tree Tops (The Collected Tales of Harry Rhine),* by Ben Earl Kitchens, M.D. Thornwood Book Publishers, Florence, Alabama, 1983.**

Ben Earl Kitchens, M.D., is known to me to be everything it seems that Mr. Harry Rhine was reputed not to be! Doctor Ben, a young and dedicated general physician of Iuka, Mississippi, could never aspire to attain the honor universally accorded Mayor Rhine as the "Biggest Liar in Tishomingo County." But in *Tomatoes in the Tree Tops (The Collected Tales of Harry Rhine)* Dr. Kitchens has faithfully recorded an important segment of northeast Mississippi folklore.

Those who knew Mr. Rhine best (including Dr. Leroy Brackstone of Corinth) confirm this book's theme that these "exaggerations" were always in good fun and good faith — never detrimental to anyone.

Every repository of folklore, every fan of Mississippi-ana, and in fact everybody who enjoys a good story will treasure this little book. An evening's reading will bring one closer to what Mississippi *has been* about (Rhine) and *is* about (Kitchens).

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NEW MEMBERS

Cannon, Charles D., Jr., Jackson. Born Bruce, MS, Aug. 10, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and internal medicine residency, University Medical Center, Jackson, 1980-83; elected by Central Medical Society.

Christian, Ronnie S., Lexington. Born Booneville, MS, Oct. 9, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Memorial Medical Center, Savannah, GA, one year; radiology residency, University Medical Center, Jackson, MS, 1980-83; elected by North Central Medical Society.

Clausen, Sally Ann, Greenville. Born Chicago, IL, Nov. 28, 1953; M.D., University of Illinois College of Medicine, Chicago, 1978; pathology residency, Methodist Medical Center, Peoria, IL, 1978-82; elected by Delta Medical Society.

Collins, R. Deaver, Jackson. Born St. Louis, MO, Aug. 7, 1952; M.D., Vanderbilt University School of Medicine, Nashville, TN, May 5, 1978; interned and medical residency, Yale New Haven Hospital, New Haven, CT, 1978-81; rheumatology fellowship, University of Alabama Hospital, Birmingham, 1981-83; elected by Central Medical Society.

Cowan, Bryan Dean, Jackson. Born Brosh, CO, Jan. 19, 1949; M.D., University of Colorado School of Medicine, Denver, May 1975; interned Portsmouth Naval Hospital, Portsmouth, VA, one year; ob-gyn residency, same, 1976-81; reproductive endocrinology fellowship, National Institute of Health, Bethesda, MD, 1981-83; elected by Central Medical Society.

Dalton, Martin Lester, Jr., Jackson. Born Columbus, GA, May 15, 1932; M.D., University of Alabama School of Medicine, Birmingham; 1957; interned Carraway Methodist Medical Center, Birmingham, one year; general thoracic and cardiovascular surgery residency, University of Mississippi Medical Center, Jackson, 1958-63; elected by Central Medical Society.

Drake, John K., Ocean Springs. Born Memphis, TN, April 10, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Baylor University Medical Center, Dallas, TX, one year; orthopedic surgery residency, University of Texas, Southwestern Medical School, Dallas, 1977-80; three-month fellowship, Basel, Switzerland; trauma fellowship, Parkland Memorial Hospital, Dallas, Jan. 1981-June 1981; elected by Singing River Medical Society.

Ethridge, H. Clark, Jr., Jackson. Born New Orleans, LA, Feb. 12, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and surgery residency, University Medical Center, Jackson, July 1979-Dec. 1980; anesthesiology residency, University of Texas, Galveston, 1981-83; elected by Central Medical Society.

Hollister, John Jamison, Starkville. Born Pascagoula, MS, Dec. 12, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family medicine residency, University Medical Center, Jackson, 1980-83; elected by Prairie Medical Society.

Horn, A. Victor, Houston. Born Houston, MS, March 12, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned Tuscaloosa, AL, one year; elected by Northeast Mississippi Medical Society.

Jackson, Joseph Alan, Biloxi. Born Little Rock, AR, July 6, 1950; M.D., Tulane University School of Medicine, New Orleans, LA, 1974; interned and psychiatry and neurology residency, Grady Hospital, Emory University, Atlanta, GA, 1975-79; neuromuscular fellowship, Baylor Medical School, Houston, TX, Feb.-Sept. 1982; elected by Coast Counties Medical Society.

Joshi, Chandrashekhar V., Philadelphia. Born India, July 6, 1951; M.D., Baroda Medical College, India, 1975; interned, same, one year; pediatric residency, New York University, New York, NY, 1977-78; pediatric residency, New York Infirmary, New York, NY, 1978-79; ob-gyn residency, Albany Medical Center, Alabany, NY, 1979-82; elected by East Mississippi Medical Society.

Judd, Thomas Kimbell, Laurel. Born Monroe, LA, Dec. 19, 1951; M.D., Louisiana State University School of Medicine, New Orleans, 1978; interned and medicine residency, Carraway Methodist Medical Center, Birmingham, AL, 1978-81; gastroenterology fellowship, Louisiana State University Medical Center, Shreveport, Nov. 1981-June 1983; elected by South Mississippi Medical Society.

Lacey, Peeler G., Laurel. Born Kosciusko. MS, June 16, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and diagnostic radiology residency, University Medical Center, Jackson, 1979-83; elected by South Mississippi Medical Society.

Milam, William Hughes, Tupelo. Born Tupelo, MS, May 29, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned Parkland Memorial Hospital, Dallas, TX, one year; general surgery and urological surgery residency, University of Texas Health Science Center, Dallas, 1978-83; elected by Northeast Mississippi Medical Society.

Monta, Mande D., Meadville. Born Philippines, July 5, 1938; M.D., Manila Central University, Manila, Philippines, 1960; interned South Side Hospital, Pittsburgh, PA, 1966-67; pathology residency, Mercy Hospital, Toledo, OH 1967-71; medicine residency, United Hospital Medical Center, Newark, NJ 1980-83; elected by South Central Medical Society.

Oosterhoudt, James Joseph, Pittsboro. Born Jacksonville, FL, Jan. 16, 1932; M.D., Emory University School of Medicine, Atlanta, GA, 1960; interned and general surgery residency, Emory University Hospital, Atlanta, 1960-65; elected by Northeast Mississippi Medical Society.

Rieves, Rafel D., Brandon. Born Amory, MS, May 10, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University Medical Center, Jackson, one year; medicine residency, Vanderbilt University Medical Center, Nashville, TN, 1980-82; medicine residency, VA Medical Center, Jackson, MS, 1982-83; elected by Central Medical Society.

Scripter, Lyman J., Ocean Springs. Born Racine, WI, June 18, 1923; M.D., University of Pittsburgh School of Medicine, Pittsburgh, PA, 1949; interned St. Vincents Hospital, Erie, PA, one year; pathology residency, Walter Reed Army Medical Center, Washington, DC, 1953-57; elected by Singing River Medical Society.

Skagerberg, David George, Gulfport. Born Minneapolis, MN, Dec. 15, 1928; M.D., University of Pennsylvania School of Medicine, Philadelphia, 1953; interned San Francisco City and County Hospital, San Francisco, CA, one year; orthopedic surgery residency, University of Minnesota Hospitals, Minneapolis, 1957-60; elected by Coast Counties Medical Society.

Tatum, Nancy O'Neal, Petal. Born Hattiesburg, MS, March 11, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family medicine residency, University Medical Center, Jackson, 1980-83; elected by South Mississippi Medical Society.

Thompson, Thomas Allan, Jackson. Born Jackson, MS, Aug. 15, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and medicine residency, Medical University of South Carolina Hospitals, Charleston, 1978-81; cardiology fellowship, University Medical Center, Jackson, MS, 1981-83; elected by Central Medical Society.

Walley, B. Schedell, Waynesboro. Born Waynesboro, MS, May 14, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned University Medical Center, Jackson, one year; elected by South Mississippi Medical Society.

Williamson, Donald Ellis, Jackson. Born Louisville, MS, June 17, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and medicine residency, University of Virginia Hospital, Charlottesville, 1979-82; elected by Central Medical Society.

Wofford, John David, Jr., Jackson. Born Philadelphia, PA, Sept. 20, 1952; M.D., Jefferson Medical College, Philadelphia, PA, 1978; interned and medicine residency, University of Alabama Medical Center, Birmingham, 1978-81; infectious disease fellowship, same, 1981-83; elected by Central Medical Society.

DEATHS

Brockmann, John L., Grenada. Born High Point, NC, Dec. 23, 1929; M.D., Duke University School of Medicine, Durham, NC, 1953; interned Hartford Hospital, Hartford, CT, 1953-55; general surgery residency, Emory University Hospital, Atlanta, GA, 1957-61; thoracic surgery residency, Grady Memorial Hospital, Atlanta, 1961-62; member of North Central Medical Society, died Oct. 24, 1983, age 53.

Little, Ashford H., Oxford. Born Wesson, MS, 1898; M.D., Tulane University School of Medicine, New Orleans, 1923; interned New Orleans; member of North Mississippi Medical Society, died Nov. 14, 1983, age 85.

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IN CONCLUSION

A new study helps document the impression that patients suffering a major depressive episode are most likely to experience relapse in the months immediately after recovery. The report, appearing in the December 23 issue of JAMA, shows that the possibility of relapses declines steadily during the following year. First-episode patients who used alcohol and other drugs in excess experienced a three-fold increase in relapse frequency compared to otherwise normal first-episode patients.

Preoperative chest x-rays are "useless" as a screening procedure for abnormalities in patients without identified risk factors for chest disease, says a study in the December 16 JAMA. Findings from a review of 905 patient charts revealed an abnormal x-ray in only one patient (0.3 percent) of the 368 who had no listed risk factor. About $25,000 could have been saved by eliminating preoperative chest x-rays in the no-risk patient group, the study's author said.

A study of weight gain and factors associated with coronary heart disease reveals sexual and racial differences. White men gain more weight from adolescence to adulthood than do white women; black women gain more than black men; and black women show nearly twice the weight gain of white women over time. Furthermore, weight gain in whites from age 18 to ages 30 to 50 was positively associated with higher values of triglycerides and systolic and diastolic blood pressure. The report is in the December 16 JAMA.

Radionuclide angiography is a highly sensitive method for determining heart function following blunt chest injuries, such as those sustained in auto accidents, according to an article in the December Archives of Surgery. In a prospective study of 35 patients, electrocardiogram abnormalities were detected in eight patients, but radionuclide angiography abnormalities were seen in 26 patients. The researchers call for further study to evaluate long-term prognosis of such patients.

Diagnostic criteria now used to identify schizophrenic patients show a high degree of diagnostic consistency over many years, according to a study conducted at the Washington University Psychiatry Clinic, St. Louis, that involved 500 patients over a 14-year period. Furthermore, the criteria select cases with a marked excess (five-fold) of probable schizophrenia among their relatives, said researchers writing in the December issue of Archives of General Psychiatry.

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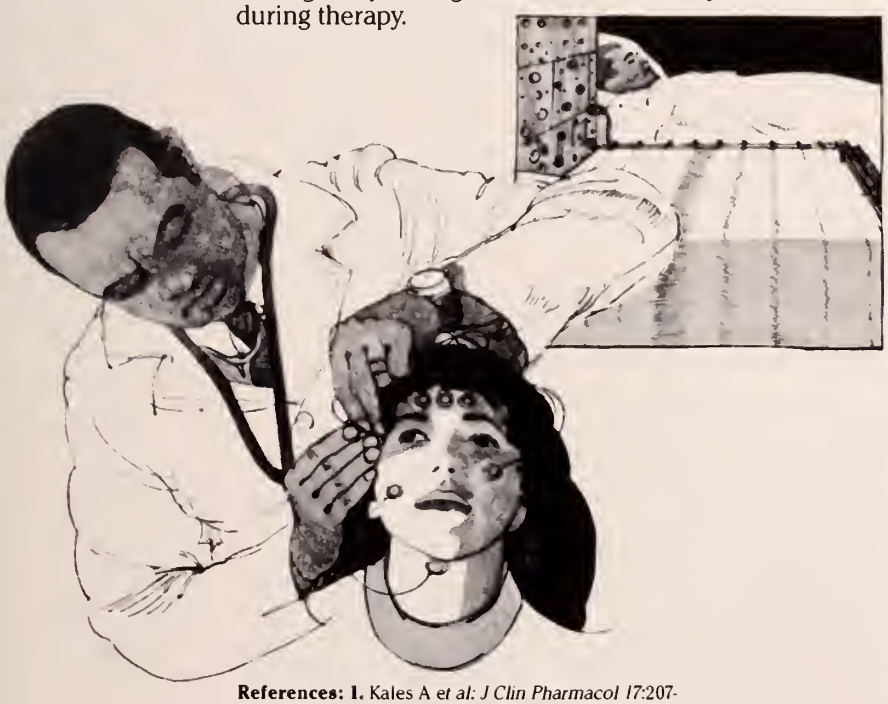

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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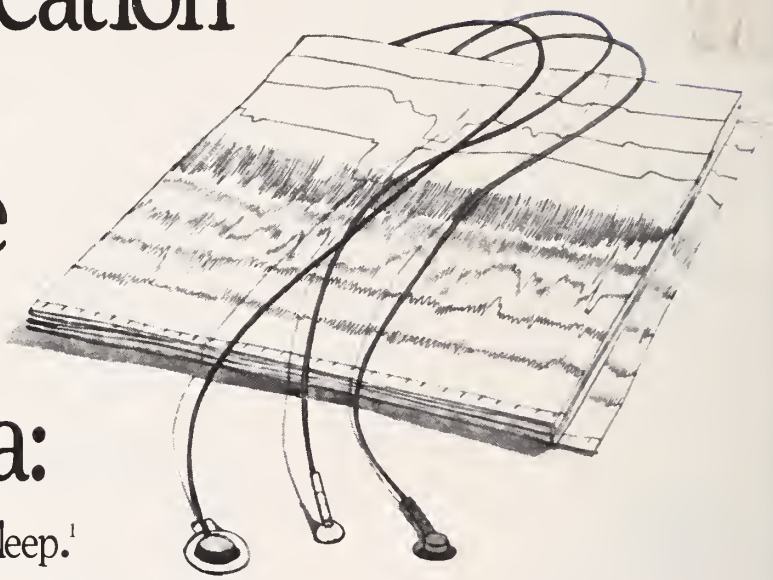

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SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.[1]

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An ero of speciolists, chop. 5, in Lee RV, Eimerl S *et al: The Physician* New York, Life Science Library, Time Inc., 1967, pp 107-109

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ROCHE

When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,[1] Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.[1]

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychopharmacology 61:* 217-229, Mar 1979. **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL®' TABLETS® Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

ROCHE®

ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm. Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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Pfizer LABORATORIES DIVISION
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

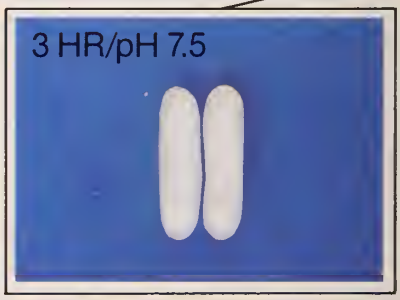
*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

ZORprin® (ASPIRIN) ZERO ORDER RELEASE

Arthritis Therapy That Checks Out.

- Gastric distress is reduced. pH-dependent matrix virtually doesn't release in acidic stomach.
- ZORprin® (aspirin) is released in the alkaline environment of the small intestine.
- Zero-order release delivers drug at a constant rate, reducing serum peaks and valleys.



- Convenient b.i.d. dosage...enhances patient compliance.
- Economical...comparable efficacy and safety as other NSAIDs, yet costs approximately one-half as much.
- Your first step in arthritis therapy... **ZORprin®** (ASPIRIN) Zero-Order Release.

Pioneers in medicine for the family

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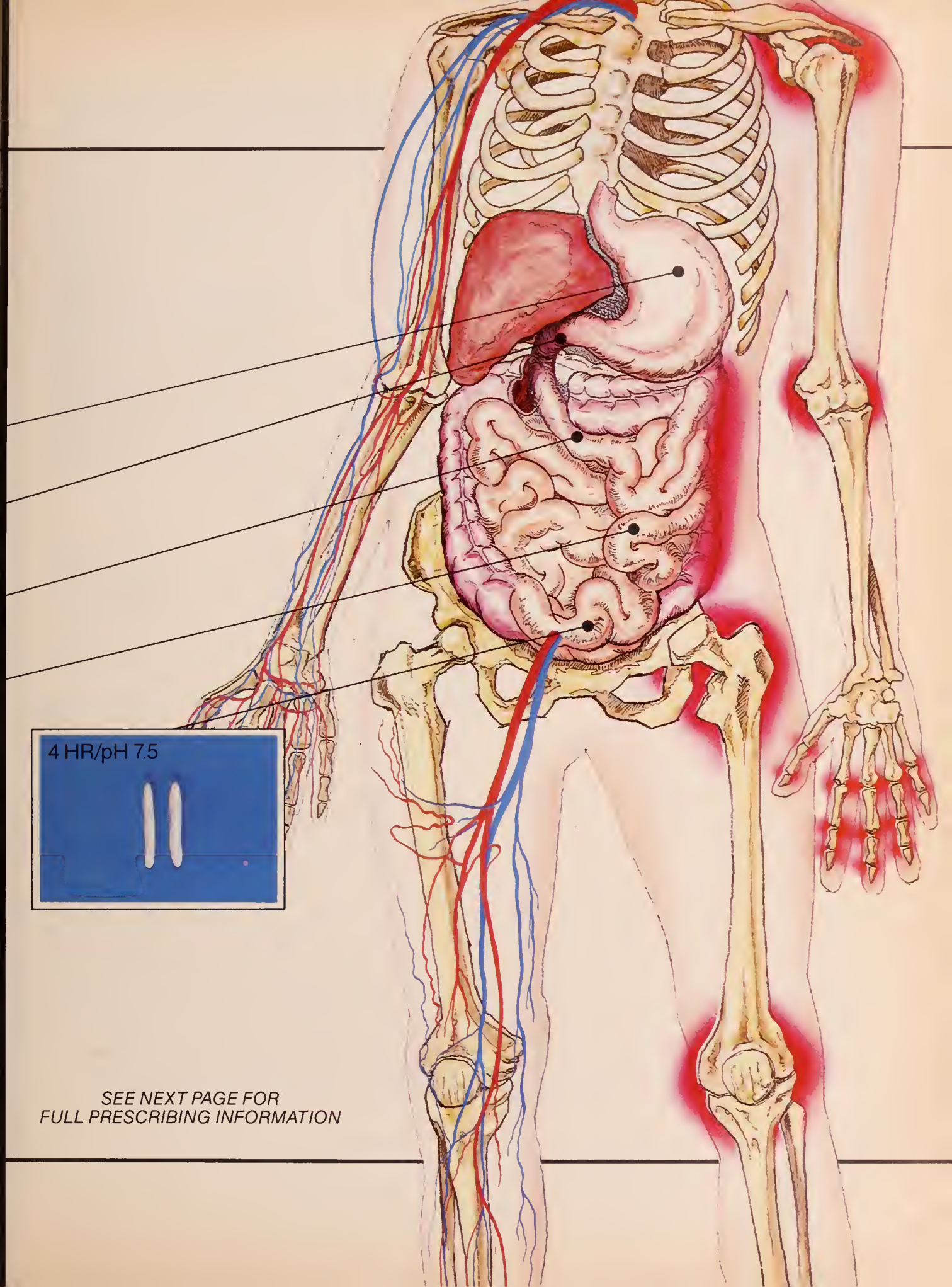
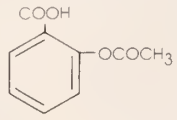


SEE NEXT PAGE FOR
FULL PRESCRIBING INFORMATION

ZORprin (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. ☐ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. ☐ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. ☐ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). ☐ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. ☐ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%), salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). ☐ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). ☐ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. ☐ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. ☐ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). ☐ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** ☐ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. ☐ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. ☐ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. ☐ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. ☐ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. ☐ Aspirin should not be taken during the last 3 months of pregnancy. ☐ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. ☐ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. ☐ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. ☐ Salicylates can produce changes in thyroid function tests. ☐ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. ☐ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. ☐ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. ☐ Aspirin may enhance the activity of methotrexate and increase its toxicity. ☐ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. ☐ **Pregnancy Category D.** See **WARNINGS** Section. ☐ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. ☐ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anti-coagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. ☐ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. ☐ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. ☐ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g. slow-reacting substance of anaphylaxis. ☐ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. ☐ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. ☐ **Renal:** Aspirin rarely may aggravate chronic kidney disease. ☐ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. ☐ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsiness, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants, salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. ☐ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) ☐ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact.* ☐ *Breaking the tablets or disrupting the structure will alter the release profile of the drug.* ☐ *It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* ☐ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. ☐ **Zorprin is not recommended for children below the age of 12.** ☐ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. ☐ Bottles of 100 Tablets — NDC 0524-0057-01. ☐ **Caution:** Federal law prohibits dispensing without prescription. ☐ U.S. Patent No. 4,308,251. ☐ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**

The structural formula of aspirin is:



12/8/83 0057-04

Pioneers in medicine for the family

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An added complication... in the treatment of bacterial bronchitis*

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary Consult the package literature for prescribing information.

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis-arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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NEWSLETTER

February 1984

Dear Doctor:

How will your practice be affected by recent legislation? What impact will current trends have on the profession? What does the future hold for medicine? If you are among the many physicians who have questions about current health issues, you may find some answers (and you will surely find some stimulating discussion) at MSMA's Health Issues Seminar, March 2 and 3, at Jackson's Sheraton Regency Hotel.

> A reception and banquet featuring Sen. Thad Cochran as guest speaker will begin the seminar Friday evening, March 2. Sen. Cochran will discuss "Health Issues Facing Congress." Alan R. Nelson, M.D., a member of the AMA Board of Trustees, will conclude the workshop the following day with a luncheon address, "The AMA Looks at the Issues."

Workshop sessions on Saturday morning, March 3, feature knowledgeable speakers and important topics:

"The Changing Dynamics of Hospital-Medical Staff Relationships" - Thomas C. Peebles, M.D., chairman of the governing council, AMA Hospital Medical Staff Section.

"Responding to an HMO Environment" - Thomas W. Hoban, executive vice president of Hennepin County Medical Society, which has been involved in developing an HMO-IPA in the Minneapolis area with 125,000 people enrolled.

"Future Trends in Medical Education" - Norman C. Nelson, M.D., vice chancellor, University Medical Center, and dean, University of Mississippi School of Medicine.

"Future Trends in Medical Licensure" - Frank J. Morgan, Jr., M.D., executive officer, Miss. State Board of Medical Licensure.

"Impact of DRG Reimbursement on Hospitals" - Jerry L. Lee, administrator, Oxford-Lafayette County Hospital and former chairman of the board of directors, Miss. Hospital Association.

"Impact of DRG Reimbursement on Physicians" - J. S. McIlwain, Jr., M.D., medical director, Miss. Foundation for Medical Care - PSRO.

To register for this important seminar, please return the form provided in the January 27 "Blue Sheet" or call the MSMA headquarters office for information.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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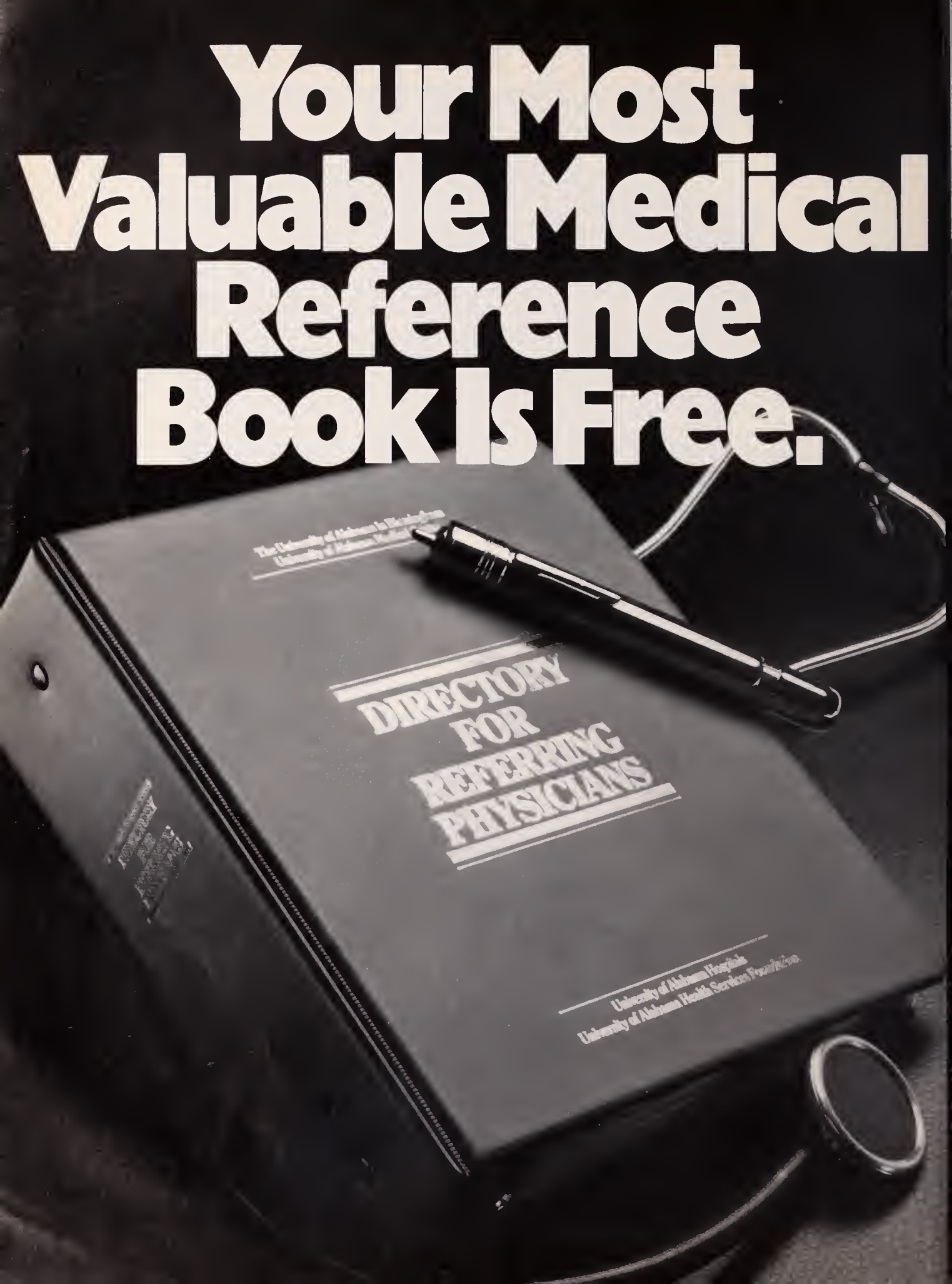

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DATELINE

World's Fair Trip on Annual Session Agenda

Jackson, MS - Plan to attend MSMA's 116th Annual Session, May 16-20 in Biloxi, and take advantage of convention rates at the Royal d'Iberville Hotel to spend a day at the 1984 World's Fair in New Orleans. Bus service is included in this special trip offer. More information about this and other Annual Session events will be published in upcoming issues of Journal MSMA and will also be distributed in mailings to members.

Medicaid Cuts Become Effective This Month

Jackson, MS - Mississippi Medicaid Commission announced cuts amounting to more than three million dollars, in an effort to keep the program within its budget. The cuts, which went into effect Feb. 1, call for these reductions: hospital days from 30 to 20 per year; physician visits from 18 to 12 per year; and prescriptions from 6 to 4 per month. Also, there will be payment for one less day per month of nursing home care.

Symposium on Sexuality Disorders

Jackson, MS - "Sexuality Disorders in Chronic Diseases" is the topic of a primary care symposium March 8-9 at the Holiday Inn North. Registration for physicians is $45. For information, contact any of the sponsors: UMC's Division of Continuing Education; Mississippi Academy of Family Physicians; and the Mississippi affiliates of the American Cancer Society, American Heart Association and American Diabetes Association.

Congress Considers Mandatory Assignment

Chicago, IL - The AMA will oppose bills that would limit the freedom of physicians to accept or reject Medicare assignment. Bills to roll back and freeze Medicare fees faced the 98th Congress when it returned late last month. Among proposals are bills requiring physicians to accept assignment or face penalties of lower reimbursement or loss of admitting privileges at hospitals participating in the Medicare program.

AMA/GTE Network Expands Services

Jackson, MS - Medical Information Network (MINET) is expanding services for physician subscribers. A drug therapy data base will go on line this spring, to add to the five existing data bases: drugs, disease, medical nomenclature, socioeconomic literature and clinical literature. Self-assessment courses through simulated patient encounters are now available. For information about the AMA/GTE network, contact Lora Lane at MSMA headquarters.

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February 1984, Volume XXV, Number 2

ORIGINAL PAPERS

Penicillamine-Induced Myasthenia Gravis

ANN MYERS, M.D.,
SUTHIN SONGCHAROEN, M.D., and
VALEE HARISDANGKUL, M.D.
Jackson, Mississippi

D-PENICILLAMINE HAS BEEN USED widely in the treatment of rheumatoid arthritis. Toxic and untoward effects are many and diverse and include several autoimmune syndromes.[1] We report a case of myasthenia gravis manifested primarily as diplopia and ptosis approximately three months after initiating treatment with D-penicillamine in a patient with rheumatoid arthritis. Symptoms resolved within two months after discontinuing penicillamine.

Case Report

A 48-year-old man with rheumatoid arthritis for ten years had persistent synovitis and prolonged morning stiffness despite treatment with several drugs. There was no history of Sjogren's syndrome, rheumatoid nodules or Felty's syndrome. He had previously been treated with prednisone 10 mg daily and various nonsteroidal antiinflammatory drugs without much improvement. Myochrysine® (parenteral gold) and azathioprine had been tried in the past but had been discontinued secondary to rash and transient trace proteinuria. Because his disease remained active, he began taking D-penicillamine (125 mg daily) which was initially well-tolerated. The dosage was increased to 250 mg daily after two months. Three weeks after increasing the dosage he developed diplopia with disconjugate vertical gaze, ptosis and weakness of extraocular muscles bilaterally as well as mild upper extremity weakness. A Tensilon test was strongly positive. Subsequent evaluation was unremarkable. Pulmonary mechanics and chest x-ray were normal, CT scans of the head and chest were normal, and antiskeletal muscle antibodies were negative. Thyroid studies were normal. ANA was negative. No antibody to acetylcholine receptor was found.

Penicillamine was discontinued when symptoms developed and Mestinon 60 mg three times daily was begun. Symptoms improved within seven days after discontinuation of the penicillamine and resolved completely within six weeks. Mestinon was discontinued after two months. Subsequent ophthalmological and neurological examinations were normal and symptoms have not recurred.

Discussion

D-penicillamine has been used in the treatment of rheumatoid arthritis.[2] This drug is a chelator of heavy metals; hence, its use in Wilson's disease. It is also an antiinflammatory agent. Rheumatoid arthritis patients experience a drop in circulating rheumatoid factor while taking penicillamine.[3] Autoimmune type syndromes are well-recognized complications of therapy with this drug. Myasthenia gravis has been reported in approximately 50 cases. The majority of cases involved patients taking greater than one gram daily for at least four months prior

From the departments of medicine, divisions of rheumatology, University Medical Center and V.A. Medical Center, Jackson, MS

to the development of symptoms.[4] The patient reported here developed symptoms after three months of treatment with a lower dosage.

The mechanism by which D-penicillamine induces myasthenia is not known. It is postulated that penicillamine induces myasthenia gravis on an immunologic basis independent of the thymus or the rheumatoid process. Some evidence implies that this phenomenon is associated with certain HLA groups including HLA-B8 or DR-w3 although this is not well documented.[5]

The immunologically mediated basis for the myasthenia gravis syndrome has been studied in some detail. Some patients have demonstrated circulating antibodies against the motor end plate and striated muscle although in lower titers than patients with classical myasthenia gravis.[6] This has been difficult to document in all cases. This antibody formation may be a later occurrence and then only in patients where the drug was continued for some time after the initial appearance of symptoms. Another proposed mechanism involves an earlier phase apparently due to a cell mediated hypersensitivity to the acetylcholine receptor.

Summary

A myasthenia gravis syndrome may occur in patients receiving D-penicillamine treatment for rheumatoid arthritis. When symptoms or signs of the syndrome appear, treatment should be stopped. Although D-penicillamine has been shown to be effective in the management of rheumatoid arthritis, its association with immunologically mediated disease should temper its widespread clinical use. The early recognition of myasthenia gravis in these patients is important since withdrawal of the drug may result in resolution of a potentially fatal disease.

★★★

2500 North State Street (39216)

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Radiological Seminar CCXXXV: Needle Localization of Occult Breast Lesions

RONALD E. GRAY, M.D.
Jackson, Mississippi

DATA FROM RECENT statistical studies indicate that aggressive mammographic screening may significantly decrease mortality from carcinoma of the breast.[1] This information has led the American College of Radiology and the American Cancer Society to revise their recommendations regarding routine mammographic examinations.

Currently, the ACS recommends that for asymptomatic women a baseline mammogram be obtained by age 35 or 40 followed by periodic (yearly or biennial) examinations from ages 40-49, and by yearly studies after age 50. In addition, the recommendations include monthly breast self-examination after age 20 with physical examination by a physician at three year intervals from age 20 through 40, and at yearly intervals afterward.[2]

Many physicians and radiologists feel that mammography is indicated in patients symptomatic of breast disease, regardless of age. The general recommendations stated above may need to be modified for women in high risk groups. Numerous epidemiologic factors have been implicated as increasing the relative risk of breast carcinoma. These have been extensively studied and well documented in the recent literature[3] and will not be dealt with in detail here.

At the University Medical Center we have performed needle/hookwire localization procedures[4] in 14 patients who presented with clinically occult mammographic abnormalities during the period from January 1 to November 7, 1983. Results of these are presented in Table 1.

Mammography is a very sensitive, but sometimes rather nonspecific screening technique. Radiographic abnormalities associated with breast carcinoma have been well documented in the recent

Figure 1. Film from localization procedure showing spring-hook wire in area of suspicion (eighth case in Table 1).

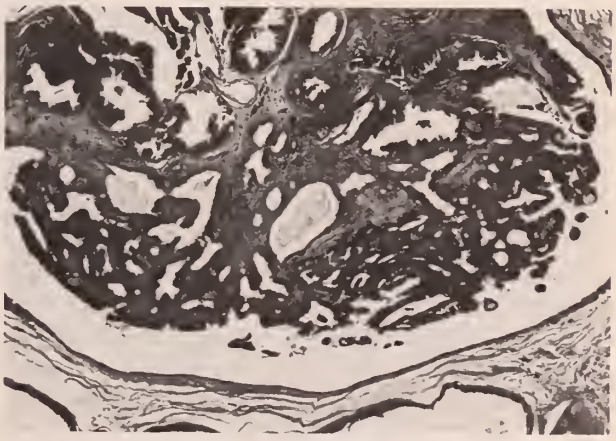

Figure 2. Photomicrograph of surgical specimen — fibrocystic disease with intraductal papilloma (original magnification 100×).

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center, Jackson, MS.

TABLE 1

RESULTS OF NEEDLE LOCALIZATIONS OF OCCULT BREAST LESIONS, 1983

Age	*Presentation*	*Mammographic Findings*	*Pathology*
43	? mass R breast	Irregular mass, no calcifications	Fibrocystic disease
49	Status post R breast abscess	Microcalcifications, L breast	Fibrocystic disease
52	Solitary pulmonary nodule; no palpable mass	Abnormal mass, no calcifications	Fibroadenoma
67	Screening	Microcalcifications	Fibrocystic disease
65	Screening	Increased density and microcalcifications	Fibrocystic disease
22	Sarcoma of leg; breast mass incidentally noted on CT of chest	Abnormal mass, no calcifications	Fibroadenoma
62	Pain, L breast	Irregular mass, no calcifications	Fibrocystic disease
60	Clinically obvious carcinoma, L breast	Abnormal mass, R. breast R breast	Sclerosing adenosis; Intraductal papilloma
64	Past history of carcinoma and mastectomy of L breast; enlarged R axillary lymph node	Increased density	R breast: fibrocystic disease Lymph node: adenocarcinoma
58	Screening	Microcalcifications	Sclerosing adenosis
47	Screening	Abnormal mass	Fibrocystic disease
63	Clinically obvious carcinoma, R breast	Microcalcifications on left	R breast: infiltrating ductal carcinoma L breast: intraductal carcinoma
71	Palpable mass	Abnormal mass, no calcifications	Fibrocystic disease
44	Screening	Mass, no calcifications	Fibrocystic disease

TABLE 2

MAMMOGRAPHIC SIGNS OF MALIGNANCY

Primary Signs	*Secondary Signs*
Mass	Irregular vs. regular borders
Asymmetric density	Skin changes
Microcalcifications	Visible node enlargement
	Invasion of retromammary space
	Increased vascular markings

literature[5] and will not be presented in detail here. They are summarized in Table 2.

Except in the most obvious and advanced cases, none of the mammographic abnormalities are entirely specific for malignancy. If one is to diagnose breast carcinoma at an early, presumably curable stage, one must be willing to accept the possibility that for every minimal carcinoma diagnosed, numerous benign lesions will be biopsied. The precise ratio depends on the patient population and how aggressive one wishes to be. Considering the fact that early findings in carcinoma are frequently subtle and nonspecific, it is the author's view that unless a lesion demonstrates convincing evidence of benignancy, such as obvious fat density, coarse calcifications, or clearly cystic characteristics on ultrasound examination, it is considered radiographically indeterminate and is so reported to the referring physician. Obviously the decision to biopsy is always a clinical one, made by the attending physician based on both mammographic findings and clinical factors. ★★★

2500 North State Street (39216)

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ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

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WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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Mental Retardation: Evolution of Care

LISA ULMER
Columbus, Mississippi

SINCE THE BEGINNING of history man has had to deal with mental retardation. During different historical periods the handicap has been looked upon with varying degrees of pity, scorn, protectiveness, and sometimes with awesome respect. Many problems have arisen from the presence of such individuals in our midst. As well as care, these problems deal with these individuals' own safety, happiness, and contribution to the community, and with society's attitudes toward them.[1]

Because there were no known cures or hope for a reverse in the situation of the mentally retarded, they were thought better off left alone. People weren't willing to spend their time or money on someone who would never be "normal." Even though several important individuals have shown the possibility for improvement in these cases, these improvements were considered unimportant. A primary example of this was encountered by one of the pioneers in the attempt to treat the mentally retarded. His name was Johann Jacob Guggenbuhl, born in 1816 in a town on Lake Zurich in Switzerland.

While in medical school, he had his interest aroused in the study of the mentally retarded by one of his professors who commented on the evidence of such individuals in certain parts of Switzerland and the problems that they encountered.

One day, when Guggenbuhl, a budding physician of 20, was passing through a village, he came upon a mentally retarded boy reciting the Lord's Prayer in front of a wayside cross. Guggenbuhl followed the boy to a dilapidated shack and spoke to the mother. She told the young physician that beginning when the child was a baby she had taught him the Lord's Prayer every day until he memorized it, but because of poverty, she was unable to spend time to provide him with the kind of education she wanted to.

Guggenbuhl suddenly had a striking idea. If he could only get the retardates early and give them a great deal of attention and stimulation and education, he could probably improve their condition until they were eventually cured. He was so sure of this that he decided to devote his life to the effort.

Although not nearly perfected, the conditions of mentally retarded individuals have come a long way. . . . The dawn of the second half of the twentieth century has brought about most of these changes.

First, he contacted one of the outstanding pedagogues and studied intensively with him so he could learn teaching methods. The educator was impressed with Guggenbuhl and gave him great encouragement. Several years later, his ideas had gained so much favorable publicity that he received the backing of the Swiss Association of National Sciences.

And so, with Guggenbuhl as its director, an institution for the care and treatment of the mentally retarded was built.

The children were given a great deal of attention, good food, plenty of exercise, and baths, as well as memory exercises and speech training. These were all performed in the hands of excellent teachers and aides.

There was some improvement in the children under his care, and the venture was hailed everywhere in the world as a major accomplishment. Guggenbuhl became internationally famous, and numerous honors were bestowed on him by medical and scientific organizations.

But in the 1850s more and more people began to realize that these children were not being cured by these methods. In 1858 the Swiss government investigated the institution and reported that "not a single person who had been admitted was ever cured."

Funds were withdrawn, and the institution was shut down. Guggenbuhl left to live in a nearby town, where he spent his time writing many articles, which with one or two exceptions, no publisher would accept. He died discredited at the age of 47.[2]

Miss Ulmer, the daughter of a physician, is a high school senior at Indiana Springs School. She has an older sister who was born severely retarded.

Although not nearly perfected, the conditions of mentally retarded individuals have come a long way since then. The dawn of the second half of the twentieth century has brought about most of these changes. This difference lies in the development of public and professional awareness of the problems and needs of the mentally retarded and the acceptance of them as individuals with a place in society.[3]

In a study conducted in the late 1940s, it was shown that many attitudes toward retardation were characterized by colossal ignorance. Only ten percent knew anything specific about it.[4]

Physicians played a major role in the awakening of interest in mental retardation. In the early 1950s, physicians, having solved many of the simpler medical problems, were able to begin devoting more time and research to more complex conditions.[5]

In a speech given in 1953 at the annual Ross Laboratories Research Conference, Dave Cox best stated the realization of need for research on the subject of the mentally retarded. He stated, "We hope to bring together results of many disciplines related to these people's problems to add perspective in which this subject will one day be more effectually viewed."[6]

As more problems were brought to light, it was discovered that there were fewer entities that involved more children and cost so much to the family, community, state and nation.[7]

Research in cases of mental retardation was so low that as interest grew, so did the widespread opportunities for many kinds of basic and applied research. Dr. Richard Masland, chief director at Memphis State Hospital at one time, said, "The field of mental retardation is one that is without boundaries. Its borders fade off into innumerable areas. Certain it is that there are few fields in which there would appear to be greater promise of reward through recent advances than in the field of mental retardation."[8]

The problems and areas concerning this subject were also well understood by several novelists. Their style of including such handicapped characters in their stories helped to include them as typical and very much a part of society. William Faulkner was one of these authors who placed them in several of his books. Though not main characters, their presence affected the outcome in each. Carson McCullars was another. In the novel *The Heart Is a Lonely Hunter,* there were several characters with major handicaps, one being retarded. Pearl S. Buck wrote the article "The Child Who Never Grew Up," which was based on her personal experiences with her own child.[9] These and others were helpful in bringing the subject of mental retardation into the public's eye.

Federal and state lawmakers have also made an important impact concerning the retarded. It was President John F. Kennedy who first involved the federal government with legislative action. The personal tragedy he knew in his life because of his mentally retarded sister prompted this action. He had seen how little had been done for her and others with her condition and was determined to do something about it.

Under his administration in 1961, a panel of experts were appointed to investigate the size of the problem in this country and to make extensive recommendations for national action. After getting the results, it was found that about one in every 100 was born retarded. To help change this ratio two legislative bills were passed. One bill authorized $265 million to be used in studies to combat mental retardation. The other provided for the construction of community-centered research centers and the training of teachers and specialists to help them.[10]

The life of President Hoover also was affected by mental retardation. His granddaughter was retarded and he often spoke of her to others.[11]

Physicians played a major role in the awakening of interest in mental retardation. In the early 1950s, physicians . . . began devoting more time and research to more complex conditions.

Bringing the subject of mental retardation out into the open and recognizing the magnitude of the problem it presents was only the first step that needed to be taken. Finding ways to solve these problems was the next.

The biggest problem was presented by society. This attitude toward the retarded has changed slowly and is still making changes. The personal value systems of most people in our culture have tended to award high status to brightness and to regard persons of low intelligence of little interest or challenge.[12]

An example of this was observed by a mother of a child born mentally retarded. Her daughter's birth had engendered an agonizing period of adaptation for her and her husband, but after several months it was developing into a sincere and abiding affection for their child. At six months the child was suddenly struck ill with acute meningitis. She spent several

troubled days in the hospital, coming very close to death. She soon began recovering and seemed to return to nearly the level of her pre-illness competency. At that time a resident working the ward for the evening asked the mother how the child was doing. She replied, "Considering that only a couple of days ago I was afraid we might lose her, she seems to be doing fine." "That's good," the doctor commented, "but for a child like her it really doesn't matter does it?"[13]

Fortunately this assignment of value to a human being who has less than normal intelligence has changed dramatically within recent years. Recent advances as the issue becomes more accepted have had some bearing on the interest in the problems of the field.[14]

Bringing the subject of mental retardation out into the open and recognizing the magnitude of the problem it presents was only the first step that needed to be taken. Finding ways to solve these problems was the next.

Traditionally, health services and medical care for the mentally retarded were provided by internal health systems which offered help only with crisis and emergency cases. Today new methods have been developed to bring health care to this specific population. There is an increased number of adults now because medical advances have kept alive infants who would have perished in earlier times.[15]

There is an increased use of outside consultants and arrangements with local hospitals and medical complexes.[16] Some states have designated one or two primary institutions as health centers where most specialized and extensive surgery is performed.[17] There is also a growing number of interns and residents doing parts of their training especially with the mentally retarded.[18] The requirements of Medicaid and other sources of medical care have recently changed to include the retarded.[19]

There are no exact census figures, but out of the approximate six million Americans impaired in their ability to learn, at least 85% represent a moderate form of retardation. Most can be taught to function at certain levels if acted on early.[20]

Previously it was thought hopeless to educate these people since they would never fully mature in society. These findings have prompted the establishment of special education classes and clinics.[21]

These classes were met with much resistance by the public. Politicians did not wish to spend time or money to hold them in public schools.[12] The establishment of private schools was an alternative, but a costly one for most parents. The only way most would ever get the special type of education they needed was their establishment as a part of the public school system.

There are no exact census figures, but out of the approximately six million Americans impaired in their ability to learn, at least 85% represent a moderate form of retardation.

Today there are many new laws concerning the education of the mentally retarded.[23] Each state now has developed a plan for mentally retarded services, including such activities as establishing requirements for school programs.[24] There has been the development of the National Network of Education Resource and Instruction Material Centers for education of the retarded.[25] Schools can and will be required to provide education for all handicapped children, including the retarded.[26]

In 1971 the Pennsylvania Association for Retarded Children won a suit against the Pennsylvania Commonwealth. A special three-judge federal panel ordered Pennsylvania to provide a free public education to all retarded children in the state. They ordered the state to identify within 90 days all retarded children not in school and to begin teaching them no later than September 1 of that year. This ruling overturned several sections of the state's Public School Code.[27]

A steady escalation of the federal contribution is also required to make available up to 40% of the actual cost of educating a child in a special education program. The State Department of Education subsidizes and offers financial assistance to school systems in an effort to make such programs more available.[28]

The care of the mentally retarded has profited considerably from the increasing availability of funds for research in many areas. Since World War II, grants for research have increased tremendously, coming from both public and private resources. This had made possible some rather extensive studies which previously had been prohibitive in cost for the individual or the institution whose funds were already insufficient to provide for the daily needs of patients. This research has resulted in better techniques for the care of the mentally retarded.[29]

Gradually, people who had remained uninvolved became more concerned and informed about the

ethical and legal problems of the retarded.[30] The last 30 years or so have witnessed a wide variety of new legislation affecting the retarded. Legal rights unheard of before have been examined and carefully defined.[31] There have been amendments made to the Social Security legislation to provide for the retarded's support.[32] In 1977 the federal government set up a protection and advocacy office in each state to meet their needs.[33] Although previously it was impossible to get health insurance for a retarded person, the issue was brought to the attention of the legislatures in many states. They upheld the view in favor of the retarded. Although not totally resolved, public notice has caused most companies to agree.[34]

Gradually, people who had remained uninvolved became more concerned and informed about the ethical and legal problems of the retarded. The last 30 years . . . have witnessed a wide variety of new legislation affecting the retarded.

Because of the better understanding that the retarded can undertake a wide range of work, the government is now training vocational counselors to help place them in appropriate jobs.[35] Before these movements were started, 600 employers throughout the nation were asked if they would hire a mentally retarded person for a minimal-skilled job and over 50% said no. Another 25% said only under extreme conditions.[36] The national campaigns urging the hiring of the retarded have shown an increase from almost non-existent to around 32,000 in 1977.[37] Sheltered workshops and industries have mushroomed job opportunities.

One of the wisest men known to us, Plato, once stated, "There are others I believe, who serve us, who have strength enough for the labors of bodily work but nothing particular in their minds which makes them worthy to be our partners."[38]

There have been changes in terminology and definitions concerning the retarded. It was thought, around the 1950s, that when a person suffered from this condition he could be represented by four terms. These four were mental retardation, cerebral palsy, epilepsy, and brain damage. They limited their scope to only these because so few people had done research in this area that that was all the knowledge they had of the subject.[39] We've come a long way since then to prove the complexity of the situation. This is a direct result of the attention that it has gained.[40]

For many years the terms idiot, imbecile, and moron were used to describe the mentally deficient.[41] By and large these aren't used any more.

The latest term used by physicians and educators is "developmental dysfunction." This is a more diagnostic definition than the previously used term, "brain damage," and allows specific naming of the defect, leading to positive treatment or training.

Today there are many other terms considered unacceptable. Some of these include brain damage, mental deficiency, mental hygiene, learning disability, and other misleading terms of pity. Terms such as handicap and cripple are used less and less because it's found that the families of the retarded are less apt to accept these.[42] Mental retardation is still the term used most, but this is slowly being changed. *Retard* means "to slow down" and this can be misleading. In most cases retardates aren't slowed down but had never reached a normal person's level.[43]

The latest term used by physicians and educators is "developmental dysfunction." This is a more diagnostic definition than the previously used term "brain damage,"[44] and allows specific naming of the defect, leading to positive treatment or training.

Up until the 1960's the question of the care of the mentally retarded was greatly simplified. The only alternative considered was institutionalization. The presence of these individuals was considered to have an adverse affect on members at home. Families were embarassed by these children.[45]

Today, institutions still play a big part in the care of the retarded.[46] Some feel that screened individuals gain benefit in an environment with persons of their own intellectual levels and with personnel specially trained to deal with them.[47]

There are also other choices for care. At present there tends to be a growing tendency to keep the child at home and to work toward community provisions for him or her.[48]

Major new changes are taking place in the field of adoption. Once concerned primarily with the placement of newborn infants, the field has broadened. There is now an emphasis placed many times on children with major handicaps. These children require special families to adopt them. The adoptive parents are usually not typical of broader society and see the adoption from the standpoint of doing something for someone else.[49]

Another new trend is the placement of the retarded in foster homes. These are usually older children who lived previously in institutions. The tendency is to place them in a rural setting where small jobs can be found to occupy their time around the house.[50]

Other placement plans available are the halfway houses and shelters. Supervised apartments provide companionship and minimal supervision for suitable adults who have lived with families but who are required to move because of a parent's death.[51] These houses are supported by public and private sources.[52] Because of the increased number of group facilities and habilitation programming, the presence of the retarded within the community has gained greater acceptance.[53]

The social balance demands that as the individual achieves more he must assume greater responsibility for the rights of others. This realization has prompted the acceptance of the mentally retarded as an integral part of every aspect of our society.[54]

With very few exceptions, mental retardation can't be cured today, but the combination of the many achievements and changes concerning retarded people gives great promise and hope.[55] It was society that condemned them in the past and it is society that gives us the hope today. It is an aspiration well worth a strong community effort and every citizen's participation. ★★★

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SPECIAL ARTICLE

Accreditation Issues: New Medical Staff Standards

JOHN E. AFFELDT, M.D.
Chicago, Illinois

The Joint Commission on Accreditation of Hospitals has adopted revised medical staff standards. This article answers some questions about the new standards.

At its December 1983 meeting, the JCAH Board of Commissioners approved a new, revised set of medical staff standards. The full text of the standards appear in the January/February 1984 issue of "Perspectives," JCAH's official newsletter, and will be published in the 1985 *Accreditation Manual for Hospitals*. Following are answers to some commonly asked questions relating to the new medical staff standards.

QUESTION: Why did the JCAH rewrite its medical staff standards?

ANSWER: The JCAH began rewriting the medical staff standards in April 1981 in response to the expanding range of hospital services, the increasing numbers of health care professionals providing services in hospitals, their broadened scopes of practice, and public policy and sentiment encouraging competition in health care. Also, developing law encouraging competition in the health care field has prompted reassessment of the legal risks that may result from standards which fail to take account of changes in the attitude of courts towards the professions. The JCAH recognized that if not properly handled, these changes could have the potential to adversely affect the quality of hospital care. Therefore, the JCAH accepted the challenge of rewriting the medical staff standards to better reflect the changing hospital environment while simultaneously helping to assure the maintenance of quality care.

QUESTION: How extensive was the field review of the standards?

ANSWER: Because of the complex nature of the issue, four drafts of the medical staff standards were developed and reviewed by the field. The JCAH mailed each draft to more than 4,000 health care practitioners, facilities, and organizations, and the standards were revised based on the field's comments. The final draft was approved by an overwhelming majority of reviewers.

QUESTION: When will the new medical staff standards become effective?

ANSWER: The JCAH will begin using the new standards to conduct surveys on July 1, 1984, and will make recommendations based on the standards for the next six months. During this transitional period, recommendations pertaining to requirements for monitoring functions, privilege delineation, and other essential elements that are related from previous standards will continue to result in contingencies or nonaccreditation decisions where indicated. To permit hospitals sufficient adaptation time, however, recommendations that relate to *new* elements in the medical staff standards will *not* result in contingencies or nonaccreditation decisions until January 1, 1985. Nevertheless, these recommendations will appear in the hospital's survey report and should be addressed by the hospital staff before the next full survey.

QUESTION: Who will compose the medical staff?

ANSWER: The standards provide that the medical staff must include physicians (MD/DO) and that medical staff membership may be granted to other licensed individuals who are permitted by law and the hospital to provide patient care services independently within the scope of their licenses and deline-

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ated privileges. Within these parameters, the new standards clearly indicate that it is up to the hospital, acting on appropriate recommendations from its medical staff, to determine medical staff composition.

It should be emphasized that the new standards do not necessarily contemplate changes in the composition of a hospital's medical staff. Rather, each facility is permitted the flexibility to select its medical staff based on hospital and community needs.

QUESTION: What is the JCAH's position regarding the appropriateness of dentists serving on the medical staff?

ANSWER: Because specific reference to dentists is not carried from current standards to the new chapter, the JCAH wishes to clarify that it has not changed its posture on the appropriateness of having dentists as members of hospital medical staffs. Rather, the intent of the new standards is to emphasize that the hospital's medical staff may include other qualified professionals.

QUESTION: Who will compose the medical staff executive committee, and what are its responsibilities?

ANSWER: The new standards state that all members of the medical staff are eligible for membership on the medical staff executive committee. The majority of members, however, must be physicians who actively practice in the hospital.

The standards ask that the medical staff executive committee assume a key role on issues central to quality care. The committee makes recommendations directly to the governing body concerning at least: the structure of the medical staff, mechanisms for reviewing credentials and delineating clinical privileges for eligible individuals, medical staff quality assurance activities, and mechanisms for terminating medical staff membership and for fair hearing procedures.

QUESTION: What are the requirements concerning delineation of clinical privileges?

ANSWER: Clinical privileges are required for all members of the medical staff and also for those who are not members but who provide patient care services independently. The standards ask that criteria be developed for determining medical staff membership and clinical privileges. Peer recommendations are recognized as part of the basis for granting privileges. All individuals with clinical privileges must have the quality of their care reviewed through designated medical staff mechanisms.

QUESTION: Who will be responsible for the admission and treatment of patients?

ANSWER: Because the privilege to admit patients is so critical to the quality of care provided by the hospital, the new standards specify that only members of the medical staff may be granted this privilege. The granting of admitting privileges must be in accordance with state law and with medical staff criteria drawn from standards of medical care. When nonphysician medical staff members are granted the privilege to admit, their patients must undergo a prompt medical evaluation by a physician. This requirement for prompt medical evaluation does not apply to qualified oral surgeons who have been granted the clinical privilege by the hospital to perform a history and physical examination. The standards also indicate that the medical care of each patient is the responsibility of a physician member of the medical staff.

QUESTION: Will there be any other significant changes relating to medical staff activities or functions?

ANSWER: The majority of material relating to medical staff responsibilities remains unchanged. For example, the new standards continue to indicate that the medical staff is responsible for monitoring and evaluating the quality and appropriateness of patient care and that the clinical performance of all individuals with clinical privileges is the responsibility of the medical staff. However, standards for medical staff monitoring functions (e.g., surgical case review, antibiotic review, pharmacy and therapeutics review, medical record review, blood utilization review) and medical staff departmental review have been modified to reflect the need for a more planned and systematic approach to quality assurance.

QUESTION: Who may be contacted for additional information pertaining to the new medical staff standards?

ANSWER: Additional questions regarding the new medical staff standards should be directed to: Donald E. Widmann, M.D., Director of Standards. Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, IL 60611.

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The President Speaking

"Grim" Fairy Tales

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

"She had so many children she didn't know what to do."
(The woman who lived in the shoe)
"She went to the cupboard but the cupboard was bare."
(Mother Hubbard)
"The sky is falling! The sky is falling."
(Chicken Little)
"Medicare is broke and getting broker because physicians are spending too much on health care."
(The Federal Government)

If you believe any of the above believe all of them because there is at least some truth and a lesson in every fairy tale; and that is what they all are. Medicare has been a fairy tale since its inception in the "Great Society" days, but it is too important a football for the politicans and bureaucrats to fumble. Of course, there will have to be some drastic changes made to meet a projected necessary decrease of 30% in expenditures or a 43% increase in income to prevent bankruptcy of the program by 1995. The costs involved are staggering and in no way fiscally sound.

Each enrollee paid into the system in 1981 an average of $11.60 per month or $139.50 per year for Part B coverage. Their Part B Benefits were then paid based on local Medicare authorized screening levels. Those in areas where payment screens were high, which by the way are the most populous areas, had more paid for Part B benefits than the less populous (lower payment screen) areas making the program even more financially unstable. For example, 320,411 Medicare recipients in Mississippi had $104,553,413 in Part B benefits paid in 1981 — an average monthly reimbursement of $27 per recipient. On the other hand, in New York, 2,313,251 Medicare recipients had $1,206 billion in Part B benefits paid in 1981 — an average monthly reimbursement of $43 per recipient. And in California 2,622,261 recipients received Part B benefits totalling $1,739 billion — an average monthly reimbursement of $55 per recipient.

If you put a pencil to these figures you find that in 1981 Medicare recipients in Mississippi paid in 42 percent of the Part B benefits they received, while in New York and California, Medicare recipients paid 26 percent and 21 percent respectively of the Part B benefits they received. Nationally, all Medicare recipients

(Continued on page 42)

EDITORIALS

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DiRGe

Funeral Hymn

Webster's Dictionary says that *Dirge* means (1) a funeral hymn, and (2) a song or composition of grief or mourning. I hope that the diagnostic related grouping movement will not be the funeral hymn for our hospital system. Certainly for us in the small rural hospitals it is foreboding. I write this as a "composition on mourning" for our present way of life or hospital livelihood as the case may be.

Chicanery

Surely the federal government has outdone itself with the development of this all-encompassing feat of chicanery. I believe the government must have a large number of active minds that have more time to think about what they can do with us (and to us) than we have smart minds to think up some way to solve all the games that we find ourselves playing with them. Yes, the DRG game is just another game that we will play; and some will win and some that can't or won't play will lose.

Shadows

The ever-lengthening shadow of government medicine has been an ominous spectre falling across the path of practicing physicians for many years. We fuss, cuss, and try to run from it, but it is always there. DRG is yet another foolish, ill-advised, ill-devised (and I hope ultimately ill-fated), dream of politicians that helps to cast that shadow a little deeper over our professional lives.

I firmly believe that if we can prove to everyone that we really do have our patients' best interest as our prime concern and work toward solving the financial dilemma that we have helped to create in a straight-forward and knowledgeable manner, then and only then should we be able to prevent that shadow from overtaking us.

Are we willing to take the time (our time)? Are we willing to make the effort? Are we intelligent enough to cope with this further intrusion into our business? I think we can, we will, and we must!

Semantics

The DRG game is one of semantics. You will note from the accompanying chart that it is very much like a chess game. If you make the right move, you win — the wrong move and you lose. But as you can see, the moves may be so subtle that you may find your self checkmated very easily. I am not advocating "diagnostic creep" as a way of winning at this game, but merely using this as one of the many rules

IMPACT OF TERMINOLOGY ON DRG'S

Drg. #	*Diagnosis*	*Drg. Rate*
297	Dehydration with gastroenteritis	$1,500.00
182	Gastroenteritis with dehydration	1,969.00
438	Alcoholism with cirrhosis	1,920.00
202	Cirrhosis with alcoholism	2,692.00
32	Concussion	1,058.00
25	Post concussion syndrome	1,550.00
134	Hypertension with CHF	2,187.00
*127	CHF with hypertension	2,996.00
391	Newborn with neonatal jaundice	691.00
389	Newborn with ABO incompatability jaundice	1,175.00
243	Herniated lumbar disc	2,089.00
215	Herniated disc with laminectomy	4,748.00
173	Carcinoma of colon	1,370.00
149	Carconoma of colon with resection	4,827.00
133	Coronary artery disease	2,438.00
122	CAD with acute MI	5,186.00
429	Senility/alzheimers	2,099.00
15	Transient cerebral ischemia	2,230.00
17	CVA	2,212.00
14	Cerebral hemorrhage	3,625.00
373	Term pregnancy, delivered	1,398.00
372	Pregnancy delivered, post partum hemorrhage	1,625.00
374	Pregnancy delivered with post partum tubal	1,914.00
132	Arteriosclerotic heart disease with congestive heart failure	1,962.69
*127	Congestive heart failure with arteriosclerotic heart disease	2,224.75

Editorial / Continued

by which this game is won or lost. In the two marked examples on the chart, you can see how crucial it is for us to know the difference between diagnoses and realize that what we may think is an inconsequential difference could in fact amount to a great deal of money one way or the other for our hospitals. As in the game of life, honesty and integrity will prevail.

In conclusion, I will expect that you and I will learn this game. We will find ourselves in a closer relationship with our hospitals than ever before. We have played and won before, so let's all work together to win again.

Thank God I am a Physician.

JOE JOHNSTON, M.D.
Associate Editor

The President Speaking

(Continued from page 40)

paid 31 percent of the Part B benefits they received in 1981 and this figure does not include the over $659 million it cost to administer the program during that year. No commercial insurance companies could operate with such losses; and if Medicare is not health insurance, it must be a fairy tale that can't come true.

The most obvious method to correct this situation would be to raise the Part B premiums to a rational level of some fiscal responsibility and apply a "means" or "need" test for either premium rates or benefit payments. Other monies could come from increasing social security taxes, general tax funds, adding excise taxes on alcohol and tobacco, special fines on moving vehicle violations such as speeding and drunken or reckless driving as well as other known health hazards, and change to indemnity coverage. After all, there hasn't been any Medicare fee around here for years that has been usual, customary or reasonable. Let's call it like it is and let the patients know what they are buying. These ideas, to be sure, are too logical and would be opposed by large groups of voters and special interest groups.

Now that the DRG's are here and prospective payment is down the road, liability will increase dramatically for physicians by decreasing our ability to "treat the patient as a whole" while not decreasing the expectations of the patients to the kind of treatment to which they have become accustomed. Already the malpractice claim rate has increased nationally since 1978 from 3.3 per 100 to 8.0 per 100 overall, and to 11.8 per 100 in high risk surgical specialties. With the cost cutbacks and practice restrictions to the medical profession, nothing is being offered to stem this liability riptide.

Just as someone filled Mother Hubbard's cupboard, as the Old Woman in the Shoe somehow raised all her children, and as someone showed Chicken Little what hit him in the head, look for Washington to come up with a scapegoat and an ending to this fairy tale that will keep 29.5 million Medicare voters happy.

With the Rostenkowski bill (HR 4170), which would guarantee physician services to Medicare patients at a price government is willing to pay, certain to reappear this year, there should be some provision for liability protection for those rendering the care and a "means test," unless the answer "Big Brother 1984" opts for is slave labor. HHS Secretary Margaret Heckler warned the AMA House of Delegates in Los Angeles this past December that if the oncoming cost cutting programs don't work, physicians will be "negotiating with an all payor system" and will have the option, when objecting "to the payment rules, of going on strike or leaving the country."

Surely there can be a more logical ending to the "Medicare fairy tale" than physicians becoming indentured servants, going on strike, or leaving the country. ★★★

LETTERS

TO DR. JOHNSTON: Congratulations on your excellent editorial in the recent issue of the State Medical Journal. I found your views stimulating and very appropriate at this time of "the big lie": that your physician is no longer available or competent to practice medicine.

How I have come to hate that nefarious term, "provider"! Of course, you are right — we have contributed to our own problems by being too "busy" to get involved in the local religious, cultural, social, and political areas.

I, for one intend to take your advice and am planning to start working with Madison Ridgeland Academy to do many of the things with which you have had such excellent results.

I will greatly appreciate your sending me your sources for securing pamphlets, movies, and planner resources for "Family Health Month."

I still believe that no one can practice medicine like a well-trained, compassionate Family Physician. I am not nearly ready to throw in the towel to these other "ninety-day wonders" or non-physician "providers"!

ROBERT T. CATES, M.D.
12 Professional Parkway
Ridgeland, MS 39157

Health Legislation Introduced As 1984 Session Begins

Concerns about the state's grim financial outlook occupied the attention of Mississippi legislators as the first month of the 1984 Regular Session drew to a close.

Preliminary activities at the beginning of the 120-day session, which got underway January 3, included adoption of rules, appointment of committee assignments, and election of leaders in both chambers. Sen. Tommy Brooks of Carthage was elected President Pro Tempore of the Senate, and Rep. C. B. "Buddie" Newman of Water Valley was re-elected Speaker of the House.

During the early weeks the theme was not entirely business as usual, however, as events included the inauguration of a new governor, the installation of a new slate of other state officials, and the settling in of a number of new legislators. With summer elections having produced a big turnover, more than 60 new members arrived at the Capitol to take their places in the legislative body.

Gov. Bill Allain made no specific legislative proposals in his January 10 inaugural address, but he did appeal for progress through a harmonious relationship between the governor's office and the legislature.

The MSMA's legislative proposals, formulated by the Council on Legislation and approved by the Board of Trustees, have been distributed to the senators and representatives. The package includes five items of suggested legislation: to provide adequate funding for the state medical examiner's office; to increase the legal age for purchase of alcohol; to revise state laws regarding epilepsy; to amend the current peer review statute; and to abolish the special defense of insanity.

Several health-related bills were introduced early in the session. In the Senate, there are bills to transfer the medical examiner's office to the Mississippi Crime Lab, to provide for involuntary commitment for chemically dependent persons, and to provide for mandatory screening of newborns for hypothyroidism, phenylketonuria and galactosemia. Other health-related bills in the Senate include a bill to increase the age for purchase of beer and light wine to 21. Another bill would provide that for medical consent purposes, an adult shall mean a person 18 years or older. Another bill to be considered in the Senate would provide for verdicts in criminal cases when the defendant asserts defense of insanity.

In the House there is similar legislation introduced with regard to increasing the age for purchase of alcohol and with regard to the insanity defense. Two other bills introduced in the House would require a person making pronouncement of death to immediately sign a death certificate, and would provide for sales tax on the sale of professional services.

Key committees in both houses will consider these and other health-related bills. Among Senate committee chairman appointed by Lt. Gov. Brad Dye are: Appropriations — Sen. Glen S. Deweese of Meridian; Public Health and Welfare — Sen. George P. Smith of Long Beach; and Judiciary — Sen. Martin T. Smith of Poplarville. Among committee chairmen appointed by House Speaker Buddie Newman are: Appropriations — Rep. F. Edwin Perry of Oxford; Public Health and Welfare — Rep.

EMCU Opens at Capitol

"Blood pressures will be rising when the search for funds begins," quipped Rep. Joel Netherland of Yazoo City, second from left, as he and Rep. Tom Reynolds of Charleston, right, stopped in at MSMA's Emergency Medical Care Unit at the Capitol. Pictured with the legislators are Dr. Marilyn Graves of Jackson, left, and Mavis Barlow, R.N. This is the 20th consecutive year the MSMA has operated the facility, where legislators, staff and Capitol visitors may receive medical attention. The unit is staffed by Mrs. Barlow and volunteer "Doctors of the Day."

Ed Buelow, Jr., of Vicksburg; Judiciary "A" — Rep. W. Terrell Stubbs, Mendenhall; and Judiciary "B" — Rep. Fred L. Banks, Jr., of Jackson.

Additional information about the progress of the MSMA-proposed bills and other health-related bills will be provided regularly during the Session in the MSMA "Blue Sheet."

Funeral Services Held In Greenville for Dr. Gamble

Funeral services were held January 6 at First Presbyterian Church in Greenville for Dr. Lyne S. Gamble, past president of the Mississippi State Medical Association. Dr. Gamble died at University Medical Center in Jackson after an illness. He was 71.

In addition to serving as president of the MSMA in 1976-77, Dr. Gamble was also a member of the MSMA Board of Trustees for nine years. He was a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology, and held membership in the American Medical Association, Southern Medical Association, and Delta Medical Society. He was a member and past president of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society. He was clinical instructor in surgery (ophthalmology) at the University of Mississippi School of Medicine.

Dr. Gamble was a member of the board of directors of the Mississippi Foundation for Medical Care from 1975 through 1980, and had been a member of the board of directors of Blue Cross-Blue Shield of Mississippi since 1975.

For 20 years he served as medical advisor of the local board of the Selective Service System. He was a member of the board of directors of the Greenville YMCA, and was an elder and former clerk of the session at First Presbyterian Church.

Dr. Gamble is survived by his wife, Pauline Black Gamble of Greenville; four sons, Dr. Hugh A. Gamble, II, and Innes Paul Gamble, both of Greenville, Lyne S. Gamble, Jr. of Winston-Salem, North Carolina, and William G. Gamble of Jackson; and three grandchildren.

The family requested memorials be made to the First Presbyterian Church in Greenville or to the Mississippi State Medical Association fund for continuing professional education.

?? What's Ahead for Medicine ??

Plan to Attend
MSMA'S HEALTH ISSUES SEMINAR

Sheraton Regency Hotel
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Friday, March 2

Reception and Banquet ..... 7:00 p.m.
- *"Health Issues Facing Congress"*
  Speaker: Senator Thad Cochran

Saturday, March 3

Registration ..... 8:00 a.m.
Discussion Sessions ..... 8:30 a.m.
- *"The Changing Dynamics of Hospital/Medical Staff Relationships"*
- *"Responding to an HMO Environment"*
- *"Future Trends in Medical Education"*
- *"Future Trends in Medical Licensure"*
- *"Impact of DRG Reimbursement on Hospitals"*
- *"Impact of DRG Reimbursement on Physicians"*

Luncheon ..... 12:30 p.m.
- *"The AMA Looks at the Issues"*
  Speaker: Alan R. Nelson, M.D.
  Member, AMA Board of Trustees

Send $25.00 registration fee to MSMA, P.O. Box 5229, Jackson, MS 39216 to reserve your place at this important seminar.

Lifestar I, an emergency medical transport helicopter, has begun service at the University of Mississippi Medical Center. Pictured, left to right, are Joseph M. Candlish, chief pilot for Lifestar I; Dr. Norman C. Nelson, UMC vice chancellor for health affairs; Dr. Stephen J. Sterling, president of EMS Helicopter, Inc., of Laguna Beach, CA; and Dr. A. W. Conerly, Sr., UMC assistant vice chancellor.

UMC Lifestar I Begins Service

The University of Mississippi Medical Center began offering a 24-hour emergency medical helicopter transport service for state residents on December 30.

Called UMC Lifestar I, the helicopter is a Bell 206-L11 medically equipped aircraft with capacity for two patients, two medical team members and the pilot. Maximum speed is 150 MPH. The helicopter's fuel range is 300 miles.

The service is designed for severely injured accident victims and patients with potentially life-threatening acute illness — anyone who needs the care a trauma center can provide. University Hospital at the Medical Center is the only health care facility in the state which meets all the criteria for a Level I trauma center according to guidelines established by the American College of Surgeons. UMC has a full range of medical specialists inhouse, including a trauma team available round the clock.

Trauma is the principle cause of death in Americans from the ages of one to 38. The death rate increases threefold with every 30 minutes which elapses between time of accident and definitive medical care. The helicopter is five times faster than ground ambulance in transporting patients.

"We believe Lifestar I will help save the lives of many people who might otherwise die from their injuries," said UMC vice chancellor Dr. Norman Nelson. "Mississippians in the remoter parts of our state will now have the same access to high level trauma care as those who live close to Jackson."

Three full-time pilots will fly UMC Lifestar I. The flight team also will include two registered nurses certified in advance cardiac life support.

Physicians, emergency room personnel, emergency medical technicians, ambulance drivers, and law enforcement officers may request the service by using a toll-free number, Dr. Nelson pointed out.

The Medical Center aircraft does not require a heliport for landing, only an area 50 feet square clear of obstacles and ground debris.

The helicopter, equipped with advanced and cardiac life support systems, will stay at University Hospital. It is kept preheated inside and out, and the flight team can be in the air two minutes after its services are requested. Patients will be billed just as they are when they are taken to the hospital by ground ambulance.

Joseph M. Candlish, a native of Senatobia, former Vicksburg police officer, and a veteran helicopter pilot is chief pilot for Lifestar I.

Toll-free number for Lifestar I Service
1-800-UMC-STAT

UMC Schedules Annual Postgraduate Surgical Forum

The eleventh annual University of Mississippi Medical Center postgraduate surgical forum is set for March 15-17 at the Holiday Inn Downtown in Jackson.

Discussion and evaluation of controversial and difficult surgical problems, surgical challenges, trauma management and selected surgical procedures will highlight the program. In addition to lectures by distinguished faculty, panel discussions with written questions from the audience will be featured at the end of each session and during luncheons.

Registrants are invited to bring problem cases, including x-rays, to present for discussion during breakfast conferences. Session topics are GI surgery, peripheral vascular surgery, biliary and pancreatic surgery and ER and ICU problems. Among special social activities scheduled during the forum are a reception followed by dinner and dancing, and tours of Natchez and Jackson for spouses.

Forum sponsors are the University of Mississippi School of Medicine Department of Surgery and the University Medical Center Division of Continuing Health Professional Education. Dr. J. Harold Conn, professor of surgery, is course coordinator and Dr. James D. Hardy, professor of surgery and chairman of the department, is co-coordinator.

Registration fee is $275. The American Medical Association will award 19.5 credit hours in Category I of the Physician's Recognition Award.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

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Biloxi Will Host Regional Meeting of ACP

The Louisiana/Mississippi Regional Meeting of the American College of Physicians (ACP) will be held at the Broadwater Beach Hotel in Biloxi, MS, March 23-24.

The meeting, one of 47 such sessions to be held this year throughout the United States, Canada, Mexico, and parts of Central and South America, will present information on developments in the field of internal medicine.

Robert E. Tyson, M.D. of Jackson is ACP governor for Mississippi. Robert R. Burch, M.D., of Tulane University School of Medicine, is ACP governor for Louisiana. For information, contact Dr. Tyson, 1600 North State Street, Jackson, MS 39202; 969-7720.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

April 4-6
1984 Family Practice Update
Holiday Inn North, Jackson

June 7-8
Sixth Annual Neurology Spring Symposium
Holiday Inn Medical Center, Jackson

August 18
Ophthalmology Update, 1984
Holiday Inn Downtown, Jackson

For more information on continuing education, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

Medical Center Establishes Paramedic-EMT Training Program

The University of Mississippi Medical Center is establishing a program to train paramedics — emergency medical technicians. It will be based in UMC's School of Health Related Professions.

Dr. Thomas E. Freeland, school dean, made the announcement following approval by the Board of Trustees State Institutions of Higher Learning.

"The curriculum will be six months in duration. We expect to award the first certificates of completion in late 1984 or early 1985," said Dr. Thomas E. Freeland, dean of the school.

Dr. Martin Dalton, professor of surgery, is medical director of SHRP's new Department of Emergency Technology and a program director will be appointed. Other faculty will be drawn from those already on staff. Training at the ambulance level is already available in the state. "Admission preference will be given to those already certified at that level, or EMT-A," Dr. Freeland said.

State law requires each ambulance to carry a certified EMT-A, and a 1976 legislative bill authorized the use of EMT-Ps on board ambulances to reduce loss of life and improve pre-hospital emergency health care services.

Paramedics are expected to benefit rural Mississippi particularly, where many patients must be treated in transit for up to two hours. For this reason, UMC expects to schedule a portion of the student's clinical internships in approved sites outside the Jackson metropolitan area.

"This new program is a cooperative effort of the University Medical Center and the State Department of Health to meet the state's need for improved health care services," said Dr. A. W. Conerly, Sr., assistant vice chancellor. "In establishing criteria for this program, we have worked closely with Dr. Alton Cobb, director of the State Department of Health; Wade Spruill, director of its Division of Emergency Medical Services; and Dr. Briggs Hobson of Vicksburg, chairman of that division's Paramedic Committee, which sets approval standards for all EMT educational programs in our state."

The UMC program parallels the U.S. Department of Transportation approved curriculum. Institution of the training is also a requirement for designation as a Level One Trauma Center according to criteria set by the American College of Surgeons. The University Hospital is the only hospital in the state which meets all the criteria for this classification.

After completing training at the Medical Center all program graduates must pass a national registration examination prior to employment as an EMT-P.

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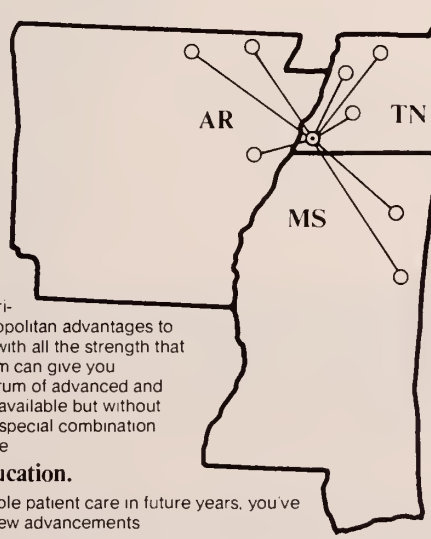

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Medico-Legal Brief

Locality Rule at Issue

The Mississippi Supreme Court has ruled that a surgeon and nurses at a Mississippi hospital were not negligent when a woman died while under their care.

The court, in a 7-2 decision written by Chief Justice Neville Patterson, found that a Circuit Court "did not err in directing a verdict for the doctor as it related to his surgical skills or expertise."

The majority said they based their ruling on previous court decisions that "negligence cannot be shown in malpractice suits without expert medical testimony that the defendant failed in some particular respect to use ordinary care and skill, unless the matter in issue is within the common knowledge of laymen."

And the court found that the matter was "of a complex nature about which laymen have no common knowledge."

The suit was filed by the husband of the deceased, who sought damages for the death of his wife, who died of heart failure in the early morning of May 21, 1978, about 15 hours after she had abdominal surgery. The plaintiff argued that the nurses should have noticed that there were "fluctuations in the vital signs of his wife late in the evening of May 20 and more so in the early hours of May 21," and called a doctor.

However, what happened was that the husband, who stayed with his wife through the night, noticed "that it looked like she was having a real hard problem breathing and she was turning pale or a bluish color." He notified the nurses, who called the attending physician, who arrived at the hospital after the patient died.

A minority opinion, written by Justice Roy Noble Lee and joined by Justice Francis Bowling, found that the deceased "did not receive the type of care that she should have received from the general surgical specialist and that he was negligent in not following this patient."

Lee added that "the highly trained, experienced, and knowledgeable surgeon was under a legal duty to closely check with and follow his patient for those complications . . . he knew might develop."

Justice Armis Hawkins, writing for himself and Justice Stokes Robertson, agreed with the majority but added in a separate opinion that "the so-called 'locality' or 'similar locality' rule on the competency of renowned physicians to testify is anachronistic, unrealistic and tantamount to a due process violation in preventing parties from having a fair trial." — *(compiled from news reports)*

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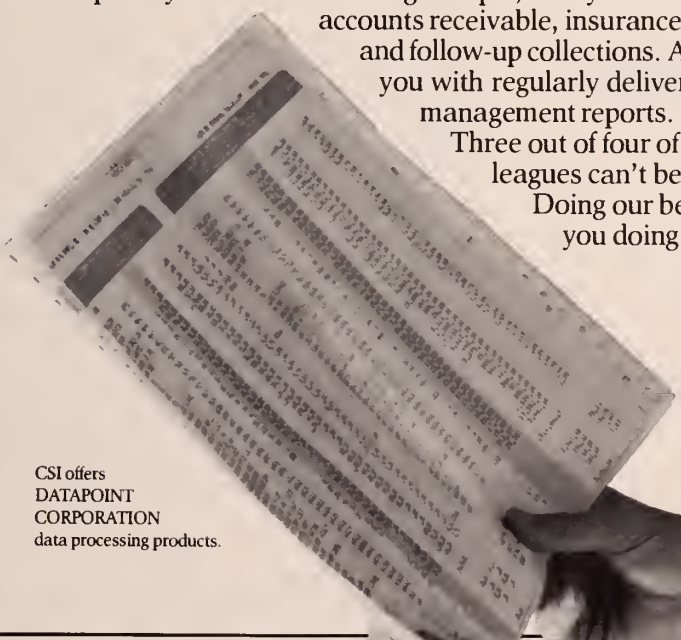

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NEW MEMBERS

Bryant, Edward E., Kosciusko. Born Meridian, MS, Aug. 15, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and family practice residency, USAF Medical Center, Wright-Patterson AFB, OH, 1975-81; elected by North Central Medical Society.

Butts, Cathy Ann, Pascagoula. Born Moss Point, MS, July 15, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and one year pediatric residency, University of South Alabama, Mobile; pediatric residency, Tulane, New Orleans, 1982-83; elected by Singing River Medical Society.

Carlton, Frederick B., Jr., Gredana. Born Memphis, TN, Sept. 25, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, University Medical Center, Jackson, 1980-83; elected by North Central Medical Society.

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Chaney, Geraldine B., Jackson. Born Meridian, MS, May 28, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and pediatric residency, University Medical Center, Jackson, 1977-81; elected by Central Medical Society.

Collins, Larry Lee, Jackson. Born Jackson, MS, Nov. 18, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, Baptist Memorial Hospital, Memphis, 1980-83; elected by Central Medical Society.

Collins, Roger L., Jackson. Born Jackson, MS, Oct. 22, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; elected by Central Medical Society.

Eakins, Maxine, Jackson. Born Harriston, MS, Sept. 4, 1949; M.D., Michigan State University College of Human Medicine, East Lansing, 1977; interned, general surgery residency, and urology residency, Ohio State University, Columbus, 1978-83; elected by Central Medical Society.

Fisher, Marc F., Hickory. Born New Orleans, Nov. 25, 1952; M.D., Louisiana State University School of Medicine, New Orleans, 1980; interned and family practice residency, College of Community Health Sciences, University of Alabama, Tuscaloosa, 1980-83; elected by East Mississippi Medical Society.

Freeman, G. Howard, Jr., Jackson. Born Meridian, MS, Sept. 29, 1927; M.D., University of Mississippi School of Medicine, Jackson 1968; interned Baptist Hospital, Jackson, MS, one year; psychiatry residency, Emory University Hospital, Atlanta, one year; psychiatry residency, University Medical Center, Jackson, MS, 1970-72; neurology residency, same, 1979-81; elected by Central Medical Society.

Gaines, Mary Sullivan, Columbus. Born Memphis, TN, Feb. 16, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned Highland General Hospital, Oakland, CA, 1979-80; radiology residency, Methodist Hospital, Memphis, 1980-83; elected by Prairie Medical Society.

Hammond, Jack L., Whitfield. Born Greenwood, MS, April 23, 1953; M.D., University of Mississippi School of Medicine, Jackson, MS, 1979; interned and psychiatry residency, University Medical Center, Jackson, 1980-81; elected by Central Medical Society.

Hawkins, Harold M., Ocean Springs. Born Norman, OK, Sept. 21, 1948; M.D., Tulane University School of Medicine, New Orleans, 1975; interned Baptist Memorial Hospital, Memphis, one year; general surgery residency, same, 1979-80; orthopedic surgery residency, Campbell Clinic, Memphis, TN, 1980-83; elected by Singing River Medical Society.

Holloman, G. H., Jr., Greenville. Born Montgomery, AL, April 17, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned University Medical Center, Jackson, 1973-74; elected by Delta Medical Society.

Irwin, Robert B., Tupelo. Born Tupelo, MS, March 11, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and medicine residency, Baptist Memorial Hosp., Memphis, 1978-81; allergy and immunology fellowship, same, 1981-83; elected by Northeast Mississippi Medical Society.

Lee, Lynda G., McComb. Born Griffin, GA, June 20, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1966; interned and pediatric residency, University Medical Center, Jackson, 1966-69; fellowship, medical genetics, same, 1969-71; elected by South Central Medical Society.

Miller, Suzanne T., Jackson. Born Rochester, NY, Aug. 22, 1934; M.D., State University of New York College of Medicine, Syracuse, 1960; interned and pediatric residency, Case Western Reserve University Hospitals of Cleveland, OH, 1960-65; fellowship, pediatric pulmonary disease, same, 1965-68; fellowship, pediatrics, Royal Melborne Childrens Hospital, Melbourne, Australia, 1963-64; elected by Central Medical Society.

Monroe, James M., Smithville. Born Palestine, TX, Sept. 13, 1944; M.D., University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1981; interned and family practice residency, Lakeview General Hospital, Battlecreek, MI, 1981-83; elected by Northeast Mississippi Medical Society.

Morgan, Marvin W., Biloxi. Born Star, MS, Feb. 22, 1925; M.D., University of Tennessee Center for Health Sciences, Memphis, 1952; interned John Gaston Hospital, Memphis, 1952-53; general surgery and thoracic surgery residency, same, 1957-64; elected by Coast Counties Medical Society.

Morris, Reuben P., Moss Point. Born Greenville, MS, July 10, 1921; M.D., Meharry Medical College, Nashville, TN, 1950; interned Phillips Hospital, St. Louis, MO, one year; family practice, University of Kentucky, Lexington 1975-76 and 1978-81; elected by Singing River Medical Society.

Murray, Donald S., Jackson. Born Syracuse, NY, June 29, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and anesthesiology residency, Rush Presbyterian/St. Luke's Medical Center, Chicago, IL, 1980-83; elected by Central Medical Society.

Nandiwada, Lakshmi, Picayune. Born India, April 24, 1952; M.D., Guntur Medical College, Andhra University, Guntur, Andhra Pradesh, India, 1974; interned and pediatric residency, Louisiana State University, New Orleans, 1979-82; elected by Pearl River Medical Society.

Palmer, Sue Mary, Jackson. Born Batavia, NY, Feb. 8, 1951; M.D., University of Arizona School of Medicine, Tucson, 1975; internship and pediatric residency, University of Tennessee, Knoxville, 1975-78; fellowship, Harbor/UCLA Medical Center, Torrance, CA, 1978-81; elected by Central Medical Society.

Patel, H. M., Tupelo. Born India, March 5, 1947; M.D., M.G.M., Medical College, Indore, M.P., India, 1972; interned and one year general surgery residency, Long Island Jewish Medical Center, NY, 1974-76; elected by Northeast Mississippi Medical Society.

Patton, George E., Jr., Jackson. Born Jackson, MS, May 9, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and medicine residency, University Medical Center, Jackson, 1979-83; elected by Central Medical Society.

Peeler, Ralph D., III, Senatobia. Born Memphis, TN., April 29, 1954; M.D., Vanderbilt University School of Medicine, Nashville, 1980; interned and family practice residency, The Medical Center, Columbus, GA, 1980-83; elected by North Mississippi Medical Society.

Powell, Ronald Edward, West Point. Born Memphis, TN, October 5, 1945; D.O., Kansas City College of Osteopathic Medicine, Kansas City, MO, 1979; interned Mount Clemens General Hospital, Mount Clemens, MI, one year; elected by Prairie Medical Society.

Rueff, W. Thomas, Jackson. Born McComb, MS, April 18, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned, gener-

al surgery, thoracic and cardiovascular surgery residency, University Medical Center, Jackson, MS, 1969-76; elected by Central Medical Society.

Russwurm, H. Dale, Hattiesburg. Born Tate County, MS, Aug. 20, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and medicine residency, Baptist Memorial Hospital, Memphis, 1973-76; elected by South Mississippi Medical Society.

Sessums, Hildon H., Jr., Vicksburg. Born Greenwood, MS, Nov. 13, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family medicine residency, University Medical Center, Jackson, 1980-83; elected by West Mississippi Medical Society.

Shields, John G., Jr., Ackerman. Born Jackson, MS, Aug. 22, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and ob-gyn residency, Ochsner Foundation Hospital, New Orleans, 1979-83; elected by North Central Medical Society.

Slonaker, Charles Edward, III, Gulfport. Born Johnson City, TN, Sept. 29, 1953; M.D., University of Tennessee College of Medicine, Memphis, 1978; interned and pathology residency, University of Tennessee, Memphis, 1978-80; pathology residency and fellowship, St. Luke's Episcopal Hospital, Houston, TX, 1980-83; elected by Coast Counties Medical Society.

Watras, Charles Stephen, Winona. Born Jackson, MS, Dec. 4, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and family medicine residency, The Medical Center, Columbus, GA, 1975-78; elected by North Central Medical Society.

Wheat, David B., Starkville. Born Stuttgart, AR, Feb. 19, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family practice, Anniston, AL, 1980-83; elected by Prairie Medical Society.

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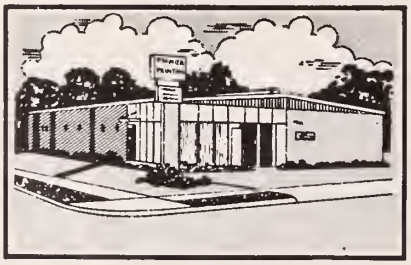

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NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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PERSONALS

James Achord of UMC taught a continuing education course at Mercer University Hospital in Macon, Georgia, in December.

Orlando Andy of UMC presented a paper at the recent Pavlovian Society meeting in Lexington, Kentucky.

Jim Barnett of Brookhaven has been appointed to the governing board of the Southern Medical Association.

Blair Batson of UMC was examiner for the American Board of Pediatrics in Chapel Hill, North Carolina.

Curtis Webb Caine, Jr., announces his association with Curtis W. Caine, Sr., of Jackson, for the practice of anesthesiology.

Michael H. Carter, Jr. of Greenwood was appointed by Governor William Winter to the Mississippi Council of Advisers in Speech Pathology and Audiology.

David G. Chase of Corinth recently was named a fellow of the American College of Chest Physicians.

J. P. Culpepper, III, of Hattiesburg was recipient of the Silver Beaver Award of the Boy Scouts of America.

C. Ralph Daniel, III, of Jackson was a speaker at the recent annual meeting in Chicago of the American Academy of Dermatology, and spoke at a family practice workshop on skin cancer at the University Medical Center in Jackson.

Nolen W. Fulton announces the opening of his office for the practice of general surgery at East Main Street in Louisville.

John Gibson of UMC presented a paper at the annual scientific assembly of the Southern Medical Association in Baltimore.

Kamal Aly Hassan announces the opening of his office for the practice of obstetrics and gynecology at Suite 238, Medical Arts Building, in Iuka.

James Hassell and James Lee Valentine have associated with Rush Medical P.A., 203-C South Main Street in Newton, for the practice of family medicine.

Donald E. Killelea of Natchez has been recertified by the American Board of Pediatrics.

Rodney Meeks of UMC lectured at the McLeod Regional Center in Florence, South Carolina, during the Annual Geriatric Symposium.

Richard Miller of UMC presented a paper at the annual scientific assembly of the Southern Medical Association in Baltimore.

Ernest H. Mitchell has been named chief of staff of Ocean Springs Hospital.

Ramesh Patel of UMC presented a paper at the Southern Medical Association's annual scientific assembly in Baltimore.

Clyde B. Phillips announces the opening of his practice of orthopedic surgery at 602 Branson Drive in Tupelo.

Mary Louise Pratt announces the opening of her office for the practice of obstetrics and gynecology at Doctors Park in Houston.

William H. Rosenblatt and Thomas A. Thompson of Jackson announce the association of George M. Reynolds, Jr., for the practice of cardiology.

Kelly Segars of Iuka attended a recent clinical review seminar at the Mayo Clinic in Rochester, Minnesota.

Clinton Smith of Laurel, president of the Jones County Chapter for the Prevention of Child Abuse, recently attended the leadership conference in Leesburg, Virginia, of the National Committee for the Prevention of Child Abuse.

James R. Stingily of Hazlehurst was named the first recipient of the Hazlehurst Chamber of Commerce's Community Pride Award.

William L. Striegel announces the opening of his office for the practice of internal medicine at Medical Plaza, 1121 VanCleave Road, in Ocean Springs.

Alfred G. Windham has associated with the Eye, Ear, Nose and Throat Clinic of Vicksburg (Chester W. Masterson and John B. Ederington) for the practice of otolaryngology, head and neck cancer surgery, and facial plastic and reconstructive surgery.

Winfred Wiser of UMC recently was an examiner for the American Board of Obstetrics and Gynecology in Chicago.

116th Annual Session
May 16-20, 1984
Biloxi, Mississippi

PLACEMENT SERVICE

Situations Wanted

OTOLARYNGOLOGIST currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

BOARD CERTIFIED FAMILY PRACTITIONER seeks location in Jackson or Greenville area with established group beginning August 1, 1984. Contact Hernando C. Payne, M.D., 1557-A Eglin Way, Washington, DC 20336.

NATIVE MISSISSIPPIAN completing pediatric residency in July 1984 seeks location in state. Contact Tom Ireland, M.D., 3516 Casawoods Lane, Clarkston, GA 30021; (404) 296-2940.

BOARD CERTIFIED internal medicine physician seeks location for small rural practice. M.D. from Johns Hopkins University. Contact Edwin B. Struve, M.D., 29 Dellwood Avenue, Chatham, NJ 07928.

Physicians Wanted

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

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ESTABLISHED GENERAL PRACTICE for sale or rent. Fully equipped, located at Southland Plaza, Louisville, MS. Contact David Wilson, Jr., P.O. Box 205, Louisville, MS 39339; telephone (601) 773-6052.

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COMMUNITY seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

GENERAL SURGEON wanted in Union, Mississippi. Seven referring GPs; attractive guarantee; office space furnished. Contact Margaret Muse or John Bradshaw, Laird Hospital, Union, MS 39365; (601) 774-8214.

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Consulting Physicians. Board eligible orthopedic and psychiatric consultants needed 25-30 hours per week for evaluation of Social Security disability claims. Positions available immediately. For additional information, please call Deborah Warriner, Medical Staff Coordinator, Disability Determination Services, (601) 923-2153.

Immediate Opportunities for physicians in the following specialties: (2) family practice; (1) internal medicine; and (1) general surgeon. Office space available, located adjacent to 50-bed, full service, general/acute care hospital. Contact Thomas J. Stone, Adm., Hardee Memorial Hospital, P.O. Box 1058, Wauchula, FL 33873. (813) 773-3101 or 773-6396.

Psychiatrists needed for Bryce Hospital, Tuscaloosa, Ala. Must be Board Certified or Board Eligible and eligible for full Alabama licensure. Salary $57,018 and up depending on training and experience. Benefits include: 13 paid holidays, 13 days annual and 13 days sick leave, excellent retirement and health insurance programs and tax deferred annuity. E.O.E. For more information contact: Tom Fanning, Director of Personnel or James V. Glass, Personnel Recruiter, Bryce Hospital, Station 3, Tuscaloosa, Ala. 35405; Phone: (205) 759-0706.

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IN CONCLUSION

Physicians should carefully monitor patients taking levothyroxine, as drug companies switch to a sensitive assay method that results in a more potent medication, says a report in the Feb. 3 issue of JAMA. More patients needed dose reductions and fewer patients needed dose increases after the manufacturer of their levothyroxine product began using high-pressure liquid chromatography to evaluate potency and consistency. The company increased the iodine content from 78% to 100% of expected potency after beginning the new technique.

As many as one-fifth of all demented patients may be overlooked by young physicians in the nation's hospitals, and an equal number of nondemented patients may be erroneously labeled as demented, according to an article on senile dementia in the January Archives of Internal Medicine. Analyses of diagnoses by 57 medical residents of 380 inpatients at Johns Hopkins Hospital indicated that admitting residents missed a diagnosis of dementia in 21% of patients judged demented by standard criteria of the American Psychiatric Association.

Continued rapid growth for the health care sector can be expected for the remainder of the decade, an AMA report indicates. According to the Center for Health Policy Research, an aging population and continuing improvements in medical technology are likely to overshadow increasing co-payments and deductibles in health insurance packages. Some economists predict that health care will account for approximately 12% of the GNP by 1990. Competition between office-based physicians and hospitals is also expected to increase, the report notes.

New findings published in the Feb. 3 JAMA contradict a 1976 study linking an increased risk of breast cancer to treatment with thyroid supplement medications. Researchers at the National Cancer Institute and the Mayo Clinic found no increase in breast cancer associated with the supplements among 1665 hypothyroid women treated between 1946 and 1964. An increased incidence of breast cancer among women who also had a history of previous breast biopsy appeared to be unrelated to the medication.

Depression appears to be a product of illness rather than a product of disappointed expectations, according to a report in the January issue of Archives of General Psychiatry. The authors tested 35 psychiatric outpatients during periods of depression and when they were free of depression. They found that dysfunctional thinking, measured by a standard test, was more prominent during depression, suggesting it was a symptom of illness and not a character trait.

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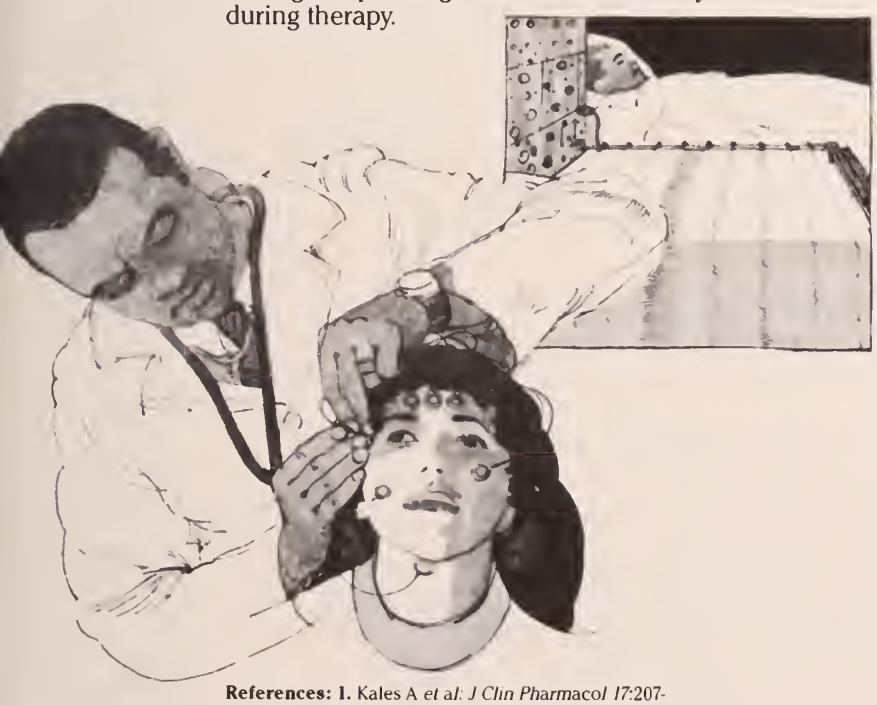

References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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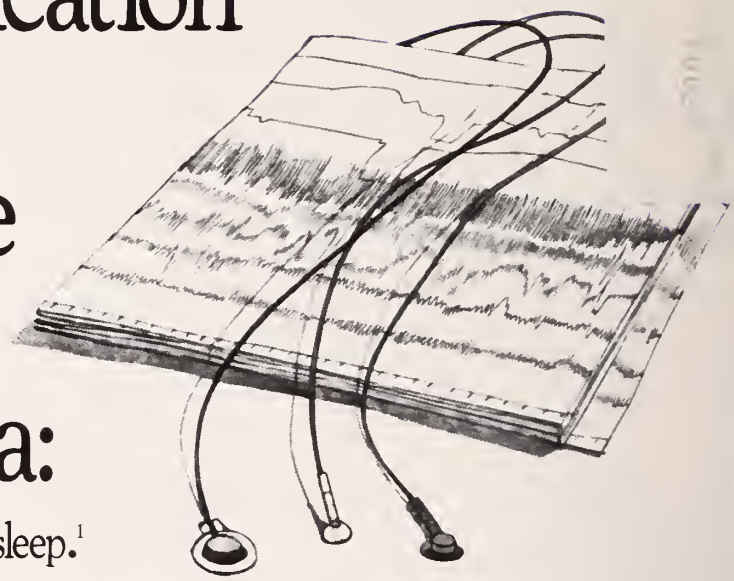

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March 1984

JOURNAL of the MISSISSIPPI State Medical Association

This Month:

Use of Calcium Channel Blocking Agents in Angina Pectoris

Radiological Seminar CCXXXVI: Intraarterial Uses for Digital Subtraction Angiography (DSA)

Primary Care Physicians In Mississippi

Preliminary Plans 116th Annual Session

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References:

1. Stone PH, Turi ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm. Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY

PROCARDIA* (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g , where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm or when angina is refractory to nitrates and or adequate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of fertility When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally the following have been reported muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container

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NEWSLETTER

March 1984

Dear Doctor:

Unless there are significant increases in projected revenues, Medicare's annual deficit will amount to more than $138 billion by the year 2005, even with the DRG system in place. That was the prediction of AMA executive vice president James H. Sammons, M.D., at the annual health policy meeting of the American Association of Retired Persons.

> Dr. Sammons charged that government officials have failed to appropriate enough funds to pay for social programs they have promised to their constituents, and said financing alternatives will not provide a magic remedy.

Physician-sponsored organizations such as state medical societies are losing their preferential treatment for qualifying as PROs, the AMA said in testimony before the Senate Health Subcommittee. The long delay in implementing the 1982 Peer Review Improvement Act has effectively wiped out the period of time Congress reserved for physician-sponsored organizations to apply for PRO designation.

Hospitals no longer are "recession-proof," according to an informal telephone survey conducted by American Medical News. Sixteen of 20 state hospital associations (including Mississippi) reported that there have been hospital layoffs in the past six months. The layoffs, unprecedented in recent decades during which hospital services expanded, appear to be due to shorter hospital stays and also to apprehension about the new Medicare prospective payment system.

If you missed Dr. Sidney Graves' "Comment" article in the December Journal MSMA, you can read it in the Feb. 24 issue of American Medical News. Dr. Graves' commentary on physician representation on hospital governing boards is reprinted in the "Other Opinion" section. Earlier, AM News reprinted a Journal MSMA article by Dr. Whitman B. Johnson on the DRG payment system.

Preliminary plans for MSMA's 116th Annual Session, May 16-20 in Biloxi, are announced in this issue. Among special guests will be Dr. Frank Jirka, president of the AMA; Dr. Phillip Gorden of the National Institutes of Health, who will present the James Grant Thompson Memorial Lecture; and television personality Willard Scott, who will entertain at the annual membership banquet. Plan now to attend!

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi, Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties. Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38665. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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316 Medical Arts Building
Jackson, MS 39201

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Northwest Mississippi Regional Medical Center
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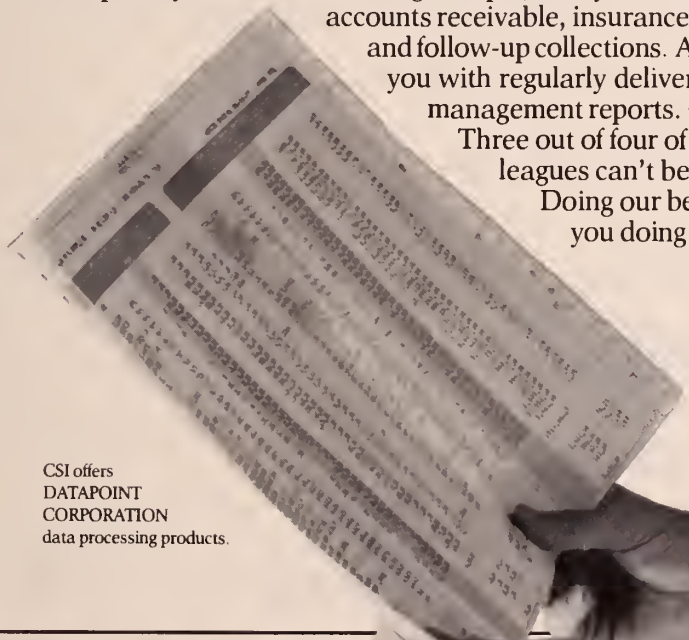

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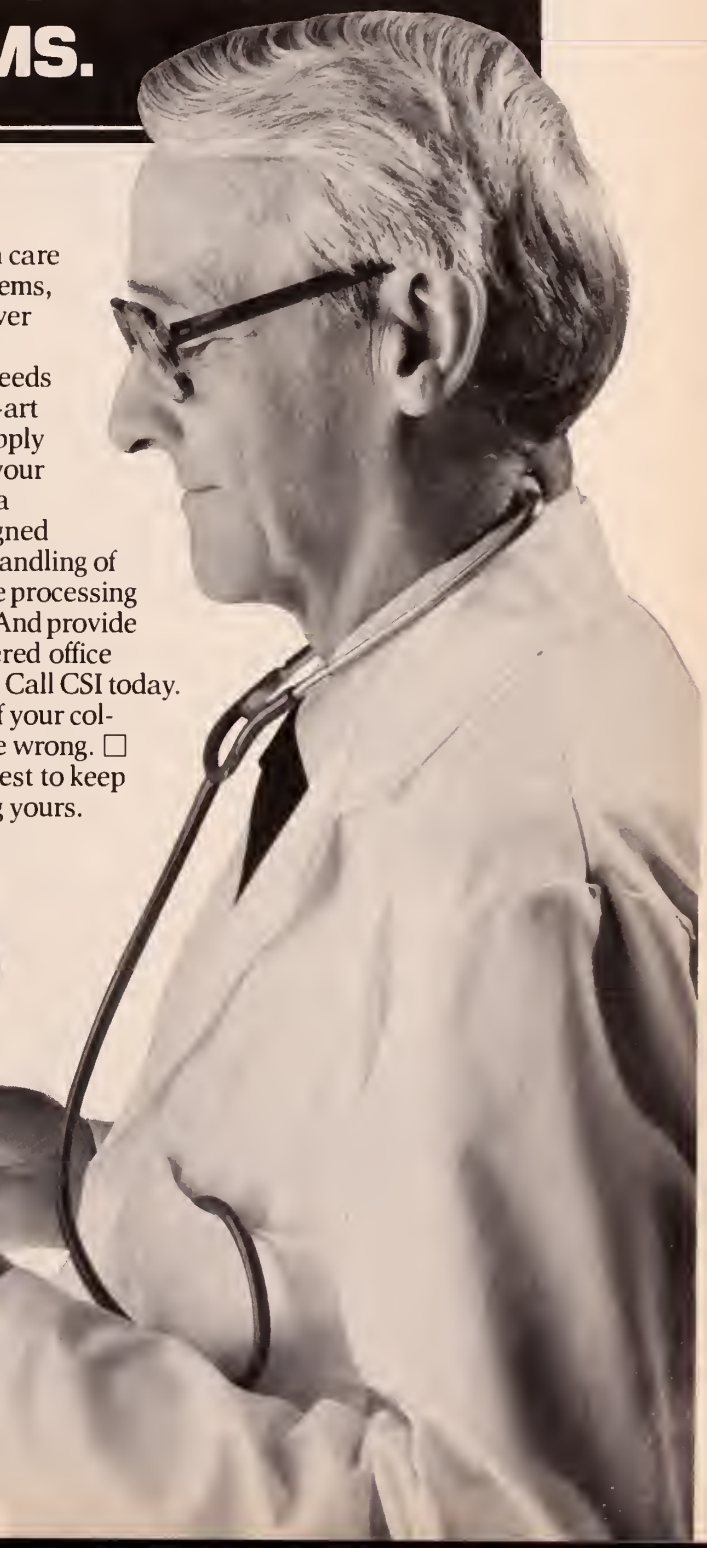

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DATELINE

Family Practice Update Scheduled

Jackson, MS - UMC's 1984 Family Practice Update is set for April 4-6 at the Holiday Inn North in Jackson. Topics include everyday problems encountered in the office and hospital, such as the new insulins, dementia, herpes, AIDS, anti-hypertension drugs, oral contraceptives, leukemia, osteoporosis, and substance abuse. For information, contact the Department of Continuing Education at University Medical Center.

Pregnancy and Antismoking Programs

Chicago, IL - Pregnant women who participate in anti-smoking programs cut cigarette consumption in half and ultimately bear babies who are significantly heavier and longer than babies of prospective mothers who don't change smoking habits, a study shows. A Feb. 17 JAMA article concludes that antismoking intervention is feasible to conduct, accepted by pregnant women, and effective in producing smoking reduction and improved birth weight of babies.

More Physicians Under Age 40

Chicago, IL - Physicians under 40 years of age made up 41.8% of the physician population in 1981, according to figures from the AMA Physician Master-file. The number of physicians under 40 increased from 167,193 (40.8% of the total physician population) in 1976 to 202,839 (41.8%) in 1981. During the same period the percentage of under-40 office-based physicians increased 10.8% while hospital-based physicians under 40 decreased slightly.

Warning Label For OTC Drugs

Chicago, IL - Over-the-counter drugs that are systemically absorbed, regardless of the route of administation, should carry a warning label advising pregnant and nursing women to seek advice from their physician or other health professional, the AMA said in comments on a proposed federal regulation. The FDA planned to require the warning only for OTC drugs intended for systemic absorption, excluding topical and suppository drugs.

Marijuana Use In Young Adults

Chicago, IL - A study of marijuana use among 1,325 young adults suggests that users were characterized by, among other things, higher use of other substances, lower participation in conventional adult roles, and histories of psychiatric hospitalization. The article, in the Feb. Archives of General Psychiatry, notes that marijuana use reaches a peak between ages 20 and 22, and declines at age 25. Social context favors use, as in adolescence.

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ORIGINAL PAPERS

Use of Calcium Channel Blocking Agents in Angina Pectoris

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The authors review the use of the calcium channel blocking agents – verapamil, nifedipine, and diltiazem – in the treatment of angina pectoris, and discuss the pharmacologic and physiologic mechanisms by which these agents exert their beneficial effect. The pharmacokinetics, side effect profiles, and studies evaluating the clinical use of these drugs are also described. These agents offer significant pharmacotherapeutic alternatives in the treatment of angina pectoris.

With the recent release of the calcium channel blocking agents, the pharmacotherapeutics of angina pectoris have significantly changed. Conventional therapy for treatment of angina has previously consisted of the nitrates and the beta-adrenergic blocking agents. While the benefits of nitrates in treating variant of Prinzmetal's angina have been demonstrated, calcium channel blocking agents (or calcium antagonists) offer a new dimension in the treatment of this type angina, having been shown to be at least as effective as the nitrates in the treatment of this syndrome. The calcium antagonists are also effective in treating classical (exercise induced) angina, although their precise role in the treatment of this disorder continues to be defined.

Physiologic and Pharmacologic Considerations

Classical angina is characterized by chest discomfort associated most commonly with exercise or emotion, and is most commonly the result of atherosclerotic coronary artery disease.[1] This type of angina has been referred to as secondary angina.[2] Angina may also be caused by other mechanisms such as coronary artery spasm, and this type has been referred to as primary angina, variant angina, or Prinzmetal's angina. Cardiac ischemia leading to chest discomfort is a result of the inability of the coronary arteries to deliver enough oxygen to meet the metabolic requirements of the heart, because of reduced supply (primary angina) or enhanced myocardial oxygen requirements (secondary angina).

From the Department of Pharmacy Services (Dr. Breland) and the Department of Medicine (Dr. Boland), University Medical Center, Jackson, MS.

The major determinants of myocardial oxygen consumption are (1) heart rate, (2) myocardial contractility, (3) afterload, a complex factor, best assessed clinically as systolic blood pressure or peripheral vascular resistance and (4) preload, actually left ventricular end-diastolic volume, best assessed clinically as left ventricular end-diastolic pressure (LVEDP) or pulmonary capillary wedge pressure (PCWP).[3] In patients with atherosclerotic coronary artery disease and secondary angina pectoris, it is felt that one or more of these major determinants of myocardial oxygen consumption are increased due to physical exertion, emotion or other factors, and that, in the setting of fixed obstruction, there is limited capability of increasing coronary blood flow. This results in a supply-demand imbalance and ischemia. Drugs such as nitrates and beta-blockers decrease the determinants of myocardial oxygen consumption, thus preventing angina.[4] The calcium antagonists also have potent peripheral

effects to decrease the determinants of myocardial oxygen consumption, and are also effective agents in control of secondary angina.

The pathophysiologic mechanisms of primary angina differ from those noted above for secondary angina. Studies have not shown primary alteration in the determinants of myocardial oxygen consumption in this type of angina. Indeed, there is a primary reduction in coronary blood flow due to coronary vasospasm in primary or Prinzmetal's angina. This, again, results in a supply-demand mismatch and ischemia. Coronary vasospasm most frequently occurs in association with fixed atherosclerotic coronary lesions, but may also occur with anatomically normal coronary arteries. Both nitrates and calcium antagonists are of proven efficacy in the control of primary angina. The roll of beta-blocking agents in the treatment of primary angina is less clear, but they are likely of benefit when there is associated fixed coronary obstruction of hemodynamic significance.

The various nitrates are first line agents in the control of primary and secondary angina.[5, 6] The mechanism of action in primary angina is to prevent or relieve vasospasm. The precise molecular basis for this action remains undefined. The mechanism of action of nitrates in the relief of secondary angina is likely a peripheral effect resulting in venous dilatation and pooling, with a resultant decrease in left ventricular volume, a major determinant of myocardial oxygen consumption. The precise role of other mechanisms such as epicardial coronary artery dilation, redistribution of subendocardial flow, increased collateral flow, and possibly minor degrees of dilatation of "fixed" lesions remains unclear.

The mechanism of action of beta-blocking drugs in secondary angina is to reduce heart rate, contractility, and systolic blood pressure.[7, 8] The role of these drugs in primary angina is unclear, as noted above. Actually, beta-blockade is potentially hazardous, resulting in unopposed alpha-adrenergic mediated vasoconstriction.[9] Though this is likely a consideration in pure rest angina of the Prinzmetal variety (associated with normal coronary anatomy), the drugs remain quite useful in the treatment of angina associated with fixed obstruction, even when a major portion of the angina is rest angina such as is seen in unstable angina.[10]

The calcium antagonists offer a new approach to the treatment of angina pectoris. Numerous review articles have appeared in the literature recently which deal with the many potential uses of these drugs.[11-15] Calcium antagonists have been shown to have numerous physiologic effects which are beneficial in the treatment of angina. Calcium antagonists inhibit, at the cell surface, the slow influx of calcium ions into vascular smooth muscle as well as cardiac muscle and conducting cells.[16] This calcium-influx blocking effect is less important in skeletal muscle, which is less dependent on extracellular calcium influx into the cell.

The calcium antagonists are beneficial in the treatment of primary and secondary angina. By blocking the "slow channel" influx of calcium in coronary arteries, vasospasm can be relieved or prevented, with a degree of efficacy at least equivalent to nitrates. The mechanisms of action in the control of secondary angina are more complex, but are probably most important peripherally by decreasing afterload, a major determinant of myocardial oxygen consumption. The role of direct coronary vasodilatation, negative inotropic and chronotropic effects, and venous dilatation are less clear.

Pharmacokinetics

Three calcium antagonists are presently on the market in the United States; (1) verapamil marketed as Calan® by Searle and as Isoptin® by Knoll, (2) nifedipine marketed as Procardia® by Pfizer, and (3) diltiazem marketed as Cardizem® by Marion. Verapamil is available in a parenteral form and indicated only for the treatment of supraventricular arrhythmias. All three drugs are available orally and indicated in the treatment of vasospastic angina and angina unresponsive to conventional therapy.

Verapamil

Verapamil is well absorbed from the gastrointestinal tract. Upon oral administration, verapamil is absorbed into the portal bloodstream and carried directly to the liver where a significant amount of the drug is metabolized. This is known as the so-called "first-pass effect." The absolute amount reaching the systemic circulation is therefore significantly reduced. Absolute bioavailability ranges from 12% to 64% with averages of 22% and 35% being reported.[15] It has also been demonstrated that this first-pass metabolism decreases with prolonged administration of verapamil, resulting in increased blood levels with chronic administration. Total body clearance has been shown to decrease from 4.2 to 1.8L/min., with long term dosing.[17] This decreased total body clearance may prove to be clinically significant in patients with already decreased hepatic blood flow, such as in congestive heart failure and congestive liver disease. Because of increased blood levels with chronic administration, it may be two to three weeks before the maximum clinical effect of verapamil is noted.

After oral administration of verapamil, peak plasma levels are reached in one to two hours.[17] Verapamil is primarily metabolized in the liver to various N- and O-dealkylated products, with norverapamil being the only known metabolite with pharmacologic activity.[18] With decreased hepatic clearance of verapamil in long term oral administration, the plasma halflife (t½) is increased from approximately six hours to around ten hours.[17] The drug is 90% bound to plasma protein.[19] With long term oral dosing of 80mg tablets every six hours, peak plasma levels range from approximately 135 to 450 ng/ml, with an average of approximately 250ng/ml.[17] There is presently no commercially available assay for determining verapamil serum levels.

In dosing verapamil, it must be remembered that the oral dose may be up to eight to ten times the intravenous dose due to the first pass metabolism by the liver. The kinetics of this drug are thus different for intravenous versus oral and short versus long term administration. Verapamil is eliminated predominantly as metabolites, with approximately 70% eliminated via the urine, 15% via the feces and only 3% to 5% eliminated unchanged in the urine.[19]

Precise recommendations regarding use of the drug in chronic renal insufficiency are not available, but in general, one should use lower starting doses and slower upward titration to the desired clinical effect.

Nifedipine

Nifedipine is well absorbed after oral administration with more than 90% of the dose being absorbed.[15, 20, 21] It does undergo approximately 20-30% first pass metabolism.[20] Absolute bioavailability is around 65% to 70% of an orally administered dose.[20] The circulating drug is 90% or more bound to serum proteins. There is no commercial assay available for determination of nifedipine serum levels. Peak serum levels occur in one to two hours after the administration of an oral dose. Sublingual or buccal administration gives peak levels sooner. Only the oral dosage form is presently available in the United States; however, the capsule may be altered for sublingual or buccal administration by simply puncturing the capsule and exposing the semiliquid contents.

Nifedipine is metabolized to inactive products with approximately 70-80% eliminated by the kidneys and 15% in feces.[20, 22] The serum half-life is reported to be from four to five hours.[12, 22] Again, no precise recommendations are available for the use of this drug in chronic renal insufficiency.

Diltiazem

Diltiazem is well absorbed after oral administration with about 80% to 90% of a dose being absorbed.[15, 23] It undergoes extensive first-pass metabolism by the liver resulting in an absolute bioavailability of about 40% of the administered dose. There is significant interpatient variability between the dose administered and the observed plasma concentrations. It is still unclear whether diltiazem exhibits linear or nonlinear elimination kinetics. Some data show serum levels increase unproportional to dosage increases, thus, suggesting metabolizing enzyme saturability with large enough doses.[24, 27]

Peak serum levels occur in two to three hours after oral administration.[23] There is no commercial assay available for diltiazem at this time; however, should such an assay become available it may prove to be clinically quite useful due to the extreme interpatient variability in serum levels and lack of patient response with low serum levels.[26] Patients unresponsive to diltiazem generally have had plasma levels below 100ng/ml.[26]

The plasma half-life of diltiazem is roughly 3.5 to 6 hours in healthy volunteers but has been found longer, up to 10 to 12 hours, in elderly subjects.[23, 26, 28] It is 80-87% bound to plasma proteins, thus leading one to suspect possible displacement interactions with other highly protein bound drugs such as aspirin.[28, 29] Studies with intravenous diltiazem show a large volume of distribution and indicate a large transfer of drug into the tissue compartment.[30]

Diltiazem is extensively metabolized to numerous metabolites of which at least one, desacetyldiltiazem, has been found to be active with 40% to 50% the activity of the parent compound.[28] Only 0.2-4% of a dose can be recovered unchanged in the urine.[26] There are no recommendations however on its use in patients with renal failure.[23] The pharmacokinetics of diltiazem appear to be unchanged after chronic treatment.[28]

Side Effects

Many of the side effects associated with the calcium antagonists are related to their vasodilatory properties. The frequency of side effects reported with nifedipine have been accumulated in over 5000 patients, with the most frequently reported being headache, dizziness, gastrointestinal disorders, tiredness, palpitations, hypotension, and leg edema.[31] The overall incidence of side effects has been reported around 15% to 17% with discontinuation of the drug necessary in 4.75% of patients.[31]

Nifedipine has the strongest vasodilator properties of the calcium antagonists, and, therefore, may cause significant hypotension, especially when combined with antihypertensive medications upon initiation of nifedipine therapy. Due to the reflex sympathetic activity, the in vitro cardiac depressant properties of nifedipine are outweighed, and, in vivo, there is no significant net effect on cardiac conduction or contractility.

Side effects with verapamil have been accumulated in over 8000 patients with an overall incidence of side effects reported of 9-10%, with about 1% requiring discontinuation of the drug.[32] With oral administration, verapamil is well tolerated. Occasional side effects include vertigo, headaches, nervousness, gastric intolerance and constipation.[33] Due to the negative inotropic effects and the negative effect on impulse generation and conduction, verapamil may cause hypotension, bradycardia and asystole in patients with compromised cardiac impulse generation or conduction, or in patients with significant left ventricular dysfunction. The combination of verapamil and beta-adrenergic blocker produces additive depressant effects on myocardial contractility, sinus node and AV node function.

The overall incidence of side effects with diltiazem is around 10%, the most common being fatigue, headache, vertigo, constipation, rash, and leg edema.[34] Precipitation of congestive heart failure, hypotension, and elevations in serum transaminases are rare occurrences. Studies have demonstrated that the overall incidence of side effects with diltiazem are no higher than that of placebo.[35]

Clinical Trials

Vasospastic Angina

The calcium antagonists have proven to be a major breakthrough in the treatment of angina resulting from coronary artery spasm.[13, 36, 37] Kimura and Kishida have shown the calcium antagonists effective in preventing anginal attacks in patients in which approximately 57% had known fixed coronary artery lesions and all had vasospastic disease.[36] Efficacy rates for nifedipine, diltiazem and verapamil were 94%, 90.8% and 85.7% respectively.

Antman et al found at least a 50% reduction in anginal attacks in 87% of 127 patients studied with known vasospastic disease when treated with nifedipine.[38] In the majority of these patients, conventional therapy of nitrates and beta-blockers had already been tried and failed. In 63% of all patients, anginal attacks were completely eliminated.

Besse et al reported 60% of patients with Prinzmetal's variant of angina pectoris had complete disappearance of attacks after being followed for up to one year on nifedipine.[39] Hosoda et al reported similar findings with 64% of patients having complete disappearance of attacks and favorable responses in 95% of patients.[40]

In comparison with the long-acting nitrates in treatment of vasospastic angina Hill et al found nifedipine and isosorbide dinitrate both effective in a double-blind crossover trial but that neither drug was clearly superior.[41] Sandoe et al demonstrated sublingual nitroglycerin effective in 11 of 11 patients with Prinzmetal's variant angina, nifedipine effective in 6 of 6 patients and varapamil effective in 6 of 6 patients.[42]

Ginsburg et al found nifedipine slightly better (not statistically significant) than isosorbide dinitrate in treating variant angina, with a patient preference for nifedipine due to less side effects.[43]

Numerous studies have documented the efficacy of diltiazem in treating variant angina.[44-47]

Classical Angina

Studies in patients with exertional angina have demonstrated significant reduction in frequency of anginal episodes, increased exercise tolerance and decreased nitroglycerin consumption.[31] Studies have demonstrated verapamil effective when compared with placebo[48, 49] and when compared with propranolol, it is at least equally effective.[50-52] Additional benefits have been reported when verapamil and propranolol were combined in treating patients with chronic stable angina.[50] This combination however must be used with caution due to the additive myocardial conduction and contractility depressant effects of both drugs.

Studies of nifedipine compared with placebo show it also effective in the treatment of stable exertional angina.[53, 54] Studies are now being reported comparing nifedipine with various antianginal medications in the treatment of exertional angina. Kenmure and Scrution found propranolol slightly better than nifedipine in treating patients with chronic exertional angina.[55] Results were not statistically significant however. The study was also in a small number of patients (21) and used relatively small doses of nifedipine (10mg every 8 hours). They did find the combination of nifedipine and propranolol more effective than either drug alone. Other studies have also found the combined therapy with these two agents more effective.[56, 58]

Diltiazem has also been proven effective in clinical trials in the treatment of classical angina when compared with placebo[59-61] Strauss et al in a multicenter ten week double-blind trial found exercise

duration statistically greater in 63 patients treated with diltiazem than in patients treated with placebo.[59] Hossack et al studied 57 patients in a double-blind triple crossover trial between diltiazem at three dosage levels and placebo. They found a significant advantage of diltiazem over placebo with the larger dose (240mg/day) being the most effective.[60]

A few studies are now being reported which have compared nifedipine and verapamil in treatment of variant angina,[62-64] and exertional angina.[65, 66] Results indicate these two drugs are approximately equally effective in both types of angina. Subramanian et al however, found verapamil more efficacious and better tolerated than nifedipine in treating patients with chronic stable angina.[66, 67] More study is needed to clarify these findings.

Clinical Application

Diltiazem, nifedipine and verapamil are available in oral dosage forms in the United States. Nifedipine is marketed by Pfizer as Procardia® in 10mg capsules, verapamil is marketed as Calan® by Searle and Isoptin® by Knoll in 80mg and 120mg tablets, and Cardizem® by Marion in 30mg and 60mg tablets. Diltiazem, nifedipine and verapamil are all FDA approved for treatment of vasospastic (Prinzmental's variant) angina and chronic stable (classic effort — associated) angina.

Verapamil is available in 80mg and 120mg tablets. The initial dosage of verapamil is 80mg three to four times a day and is titrated to the patient's response. Dosage may be increased about every 24 to 48 hours, but it should be remembered that the half-life and serum levels increase with continued oral use. The total daily dosage range is 240 to 480mg. It has been suggested that many treatment failures are related to a failure to use high enough doses. Unless complications appear, verapamil should be increased to the upper dosage range.

One should also keep in mind that the negative inotropic effects of verapamil are more pronounced with the higher dosage. In patients with marginal cardiac hemodynamic status, these negative inotropic properties may prove detrimental. Congestive heart failure may be worsened, or a patient with compensated congestive failure may decompensate when placed on verapamil. The combination of verapamil and cardiac glycosides must be used with caution since both will depress A-V node conduction. Verapamil has also been reported to elevate serum digoxin levels[68, 69] similar in magnitude to the elevation caused by quinidine. Patients should be monitored for symptoms of digoxin toxicity when using the drugs concurrently.

Nifedipine is available in 10mg capsules. The recommended starting dose of nifedipine is 10mg three to four times a day. This dosage may be increased to 30mg three to four times daily. Daily doses above 180mg are not recommended. As with verapamil, nifedipine must be titrated to the patient's response; however, doses of 20mg three to four times a day are usually effective.

Diltiazem is available in 30mg and 60mg tablets. Diltiazem should be initiated at a dosage of 30mg four times a day, before meals and at bedtime, and gradually increased to a maximum recommended dosage of 240mg per day in divided doses.[23] The higher dosage has been necessary in some studies to achieve adequate serum levels and clinical response and, indeed, generally higher doses may be required in some patients.

The intermediate effects of diltiazem on AV conduction may result in additive effects when used concomitantly with digitalis or beta-blockers; therefore, a combination of diltiazem with either of these drugs should be used with caution in patients with left ventricular dysfunction or impulse generation or conduction abnormalities.

Each of the calcium antagonists have demonstrated efficacy in the treatment of a wide variety of patients with angina pectoris. Though it cannot be said that one agent is more effective than the others, some clinical guidelines to the selection of a particular agent can be made. Probably most important is that the clinician should use the agent he feels most comfortable prescribing. In general, the side effect profiles are better with verapamil and diltiazem compared to nifedipine, particularly when used alone. Nifedipine, on the other hand, is an excellent drug used in combination with beta-blocking drugs, and probably has less significant side effects of vasodilation and reflex tachycardia when used in this combination. In patients with a significant contraindication to beta-blocking drugs, such as those with diabetes, broncho-spastic lung disease, or severe peripheral vascular disease, verapamil or diltiazem might be the better choice. Patients having coexisting angina and paroxysmal supraventricular tachycardia or atrial fibrillation with a rapid ventricular response may be best treated with verapamil or, perhaps, diltiazem. Patients with more severe LV dysfunction are probably best treated with nifedipine or diltiazem, as the myocardial depressant effect of verapamil may be significant in this situation. However, there is usually no problem with using verapamil in lesser degrees of LV dysfunction. Combined use of verapamil and disopyramide

(Norpace®) should be undertaken with caution because of additive myocardial depressant effects. The verapamil-digoxin interaction has been noted above; this interaction is important because of the increase in digoxin blood levels and because of the combined depressant effect on AV node conduction.

The exact role of the calcium antagonists in the treatment of ischemic heart disease is yet to be defined. Clearly the nitrates are first line agents in the acute treatment and long-term prophylaxis of primary and secondary angina. Some have advocated a "step" approach with beta-blockers being second line followed by the calcium antagonists. This is probably a simplistic approach. As in so many other situations, throughtful considerations of the individual patient's needs will best determine whether beta-blockers or calcium antagonists are the best second line choice, and best determine which of the calcium antagonists is most appropriate. For example, in many patients there are relative or absolute contraindications to the use of beta-blockers and a calcium antagonist would be the second line drug of choice. In patients with a more predominant rest angina pattern, calcium antagonists may be the most appropriate second line agents. Additionally, for reasons which are not well-defined, some patients respond to one class of drugs and not to the others. This has led some to recommend discontinuation of beta-blockers and a trial of calcium antagonists if therapy with beta-blockers has not been efficacious. Obviously, if calcium antagonists have not been effective, discontinuation and a trial of beta-blockers would also be suggested. There are those refractory patients who may not be candidates for invasive therapy, who will require nitrates, beta-blockers and calcium antagonists for control of angina.

The calcium antagonists have been used effectively in combination with beta-blockers. Nifedipine in combination with a beta-blocker, has been quite effective in the relief of angina and this combination of agents is relatively free of side effects as the vasodilatory and reflex tachycardia are less marked. Considerable concern has been noted in the combined use of verapamil with beta-blockers because of additive depression of contractility and conduction. However, clinical studies have shown this to be an effective and safe regimen, particularly in patients with no evidence of LV dysfunction.

Conclusion

In summary, the calcium antagonists are a significant addition to the practitioner's armamentarium for the treatment of angina pectoris. Their precise role will be determined after additional clinical trials are completed. It is without question that these agents are more effective than placebo; however, there are somewhat conflicting reports on comparison trials of calcium antagonists with nitrates and beta-blockers.

It appears that for the present time the calcium antagonists role in the treatment of variant angina is in the prophylactic management in combination with sublingual nitroglycerin for acute attacks (sustained release nitrates in addition to the calcium antagonists are optional). In exertional angina, the calcium antagonists should be reserved for the treatment of patients unresponsive to the conventional nitrates and beta-blockers or in whom the beta-blockers are contraindicated. Additional study may lead to earlier use of these agents, but at the present time the data is insufficient to support this. It is clear that the combination of the nitrates, beta-blockers and calcium antagonists is the most effective therapy in exertional angina and may be necessary with severe coronary artery disease. ★★★

Dr. Breland: 2500 North State Street (39216)

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Radiological Seminar CCXXXVI: Intraarterial Uses for Digital Subtraction Angiography (DSA)

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INTRAARTERIAL DIGITAL SUBTRACTION angiography (DSA) is an imaging modality which is becoming a useful alternative in the angiographic evaluation of numerous medical problems.[1-5] This article discusses some of the ways in which this modality has been utilized at our institution, the advantages of the procedure as opposed to conventional arteriography and intravenous digital subtraction angiography, and the current limitations of the technique.

One of the major advantages of intraarterial DSA is the reduced contrast volume utilized per injection as compared to both conventional angiography and intravenous DSA. Figure 1 demonstrates a radiograph from a conventional abdominal aortogram and a matched image from an intraarterial DSA performed upon the same patient. Both images demonstrate a stenotic lesion of the proximal left renal artery. A standard injection volume of 60 cc of MD 76 was utilized for the conventional aortogram, but only 5 cc of Hypaque 60 (mixed with 25 cc of normal saline to yield a total injection volume of 30 cc) was utilized during the intraarterial DSA. Figure 2 demonstrates an AP view of the aortic arch and origins of the great vessels in a different patient. Twenty cc of MD 76 (with no saline dilution) was utilized during this injection. A conventional arteriogram would

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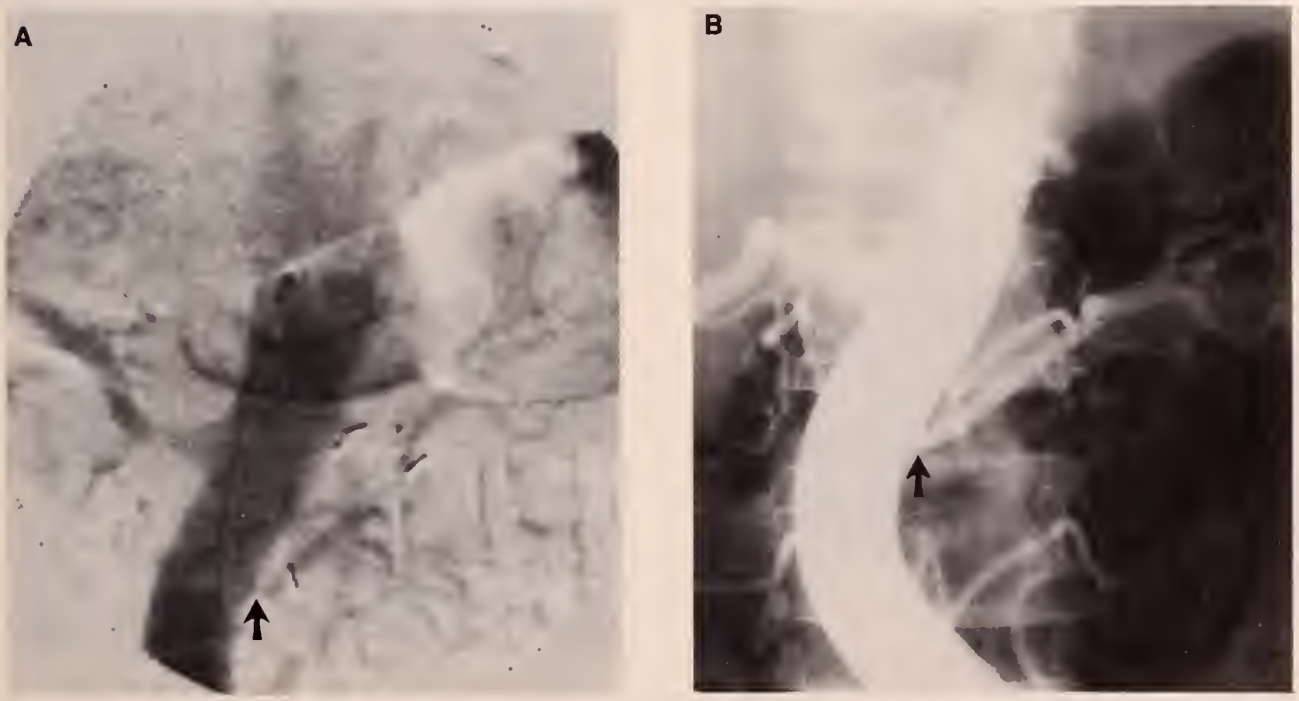

Figure 1. (A) Intraarterial DSA and (B) conventional aortogram demonstrating stenosis of the proximal left renal artery. (Surgical clips represent a failed bypass graft.)

have required 60-70 cc of contrast to obtain a comparable image. Although the quality of this particular image is inferior to a conventional aortogram, it serves a very useful function as a vascular "road map" during difficult catheterizations. While intravenous DSA often utilizes less contrast per injection than conventional aortography, the contrast volume utilized per injection is usually considerably more than (2 to 8 times) the amount required for a similar intraarterial DSA injection. The reduced contrast volume which is utilized for intraarterial DSA has obvious advantages for patients with renal failure (see Figure 3). The technique is similarly advantageous for studies which may require either the injection of multiple vessels or many different projections necessitating multiple injections. Our experience also suggests that there is less patient discomfort with the reduced contrast volume.

Investigators have found the resolution of intraarterial DSA to be nearly comparable to film-screen angiography for vessels greater than .2 to 1 mm in diameter,[1, 5] but smaller vessels are not as well resolved. However, despite the reduced contrast volume, this modality has been found to be more sensitive to contrast density than film-screen angiography with subtraction radiographs.[1, 2, 5] Figure 4 demonstrates different phases of an intraarterial DSA of a large neurofibrosarcoma of the left arm. The tumor blush is easily seen. While the tumor blush could be identified on film-screen subtraction radiographs of the same patient, the tumor blush was much less apparent on the radiographs than on the digital study. The fact that the digital subtraction images can be reviewed during the procedure is also quite helpful, especially in cases such as parathyroid angiography.[3]

In our experience, one of the major limitations of intravenous DSA has been the necessity for patient

Figure 2. Intraarterial DSA of the aortic arch. A = aorta, i = innominate artery, c = common carotid artery, s = left subclavian artery, arrow = left vertebral artery.

Figure 3. Intraarterial DSA demonstrating widely patent renal arteries in a patient with renal failure. A = aorta, r = renal artery, i = common iliac artery.

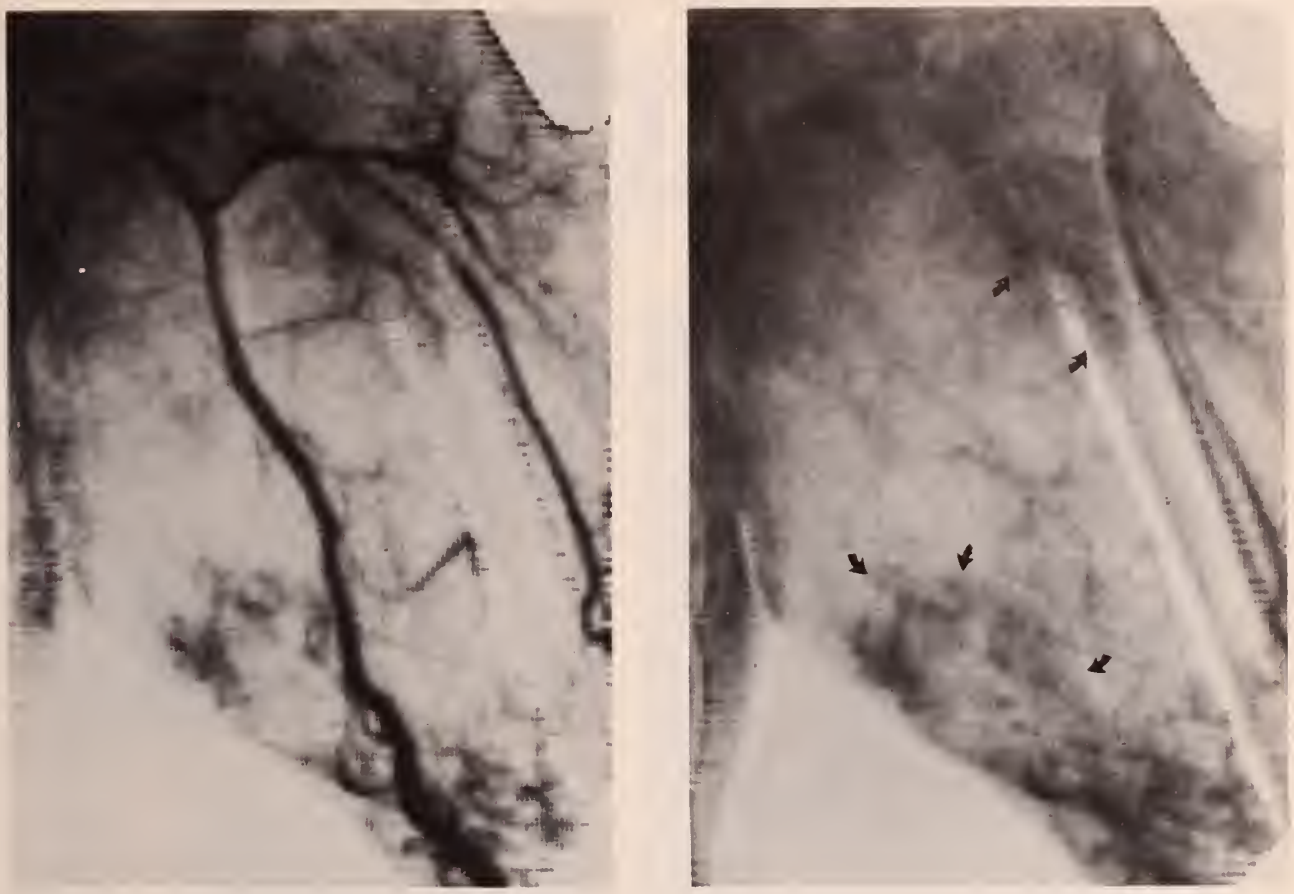

Figure 4. Intraarterial DSA of large neurofibrosarcoma of left arm. Arrows indicate areas of tumor vascularity.

immobility and suspended respiration over relatively long periods of time. The imaging time for intraarterial DSA is considerably shorter than for venous studies, and it is easier for patients to remain immobile during the filming sequence.

At the present time, intraarterial DSA has most of the same relative contraindications as conventional arteriography. Patients with severe, uncontrolled hypertension or a clotting disorder are poor candidates as both of these conditions make it difficult to achieve hemostasis after removal of the catheter. The patient must have absolute bed rest for several hours after the study is completed, and the puncture site and patient's vital signs must be closely monitored for several hours. For these reasons, the procedure is usually performed on an inpatient basis. Smaller catheters (3-4 French) are currently being developed, and if they prove useful, they may make it possible to perform the procedure on an outpatient basis. These smaller catheters may also expand the usefulness of the modality in the pediatric population.

In conclusion, we have found intraarterial DSA to be very useful in evaluating a number of patients. This modality appears very promising and should become even more widely utilized in the future.

★★★

2500 North State Street (39216)

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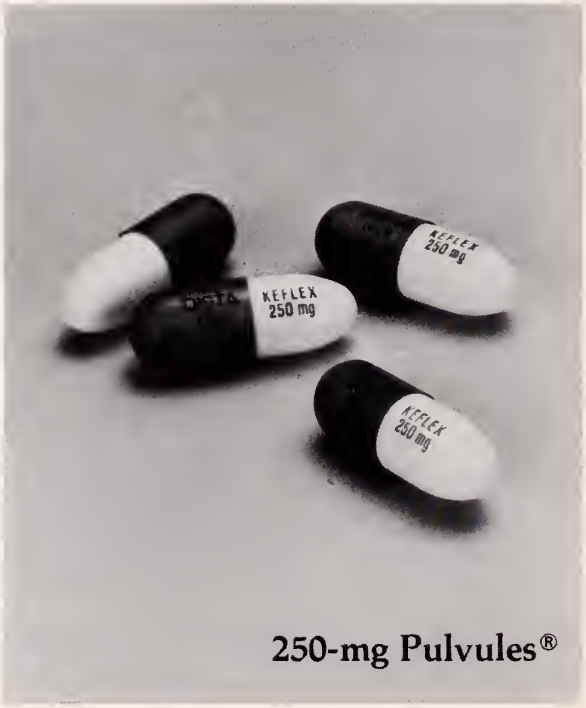

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SPECIAL ARTICLE

Primary Care Physicians in Mississippi

FRANK M. WIYGUL, JR., M.D. and W. R. GILLIS, M.D.,
Jackson, Mississippi

THE SURPLUS OF PHYSICIANS available in the United States in the next two decades has been widely recognized and discussed. Prediction of an increase in the number of physicians in the United States of more than 40% in 1990 as compared to 1978 seems justified. Closer examination suggests that the surplus will be relative depending on the medical specialty and the geographic location.[1] It appears that the medical and surgical subspecialties and some of the supporting specialties will be over supplied, while the primary care specialties will continue to be needed.* Likewise, the distribution of physicians in the population is not uniform and maldistribution together with specialization results in under-served areas despite overall satisfactory physician to population ratios (see Figure 1).

This study proposes to examine the supply and distribution of primary care physicians (family physicians, general practitioners, general internists and pediatricians) in Mississippi and to predict from the best information available to us what the needs are now and for the future.

A projection of need for primary care physicians over the next 20 years is made based on population growth, probable attrition, and current physician shortage and present maldistribution. The need for primary care physicians is compared to the probable output of training programs.

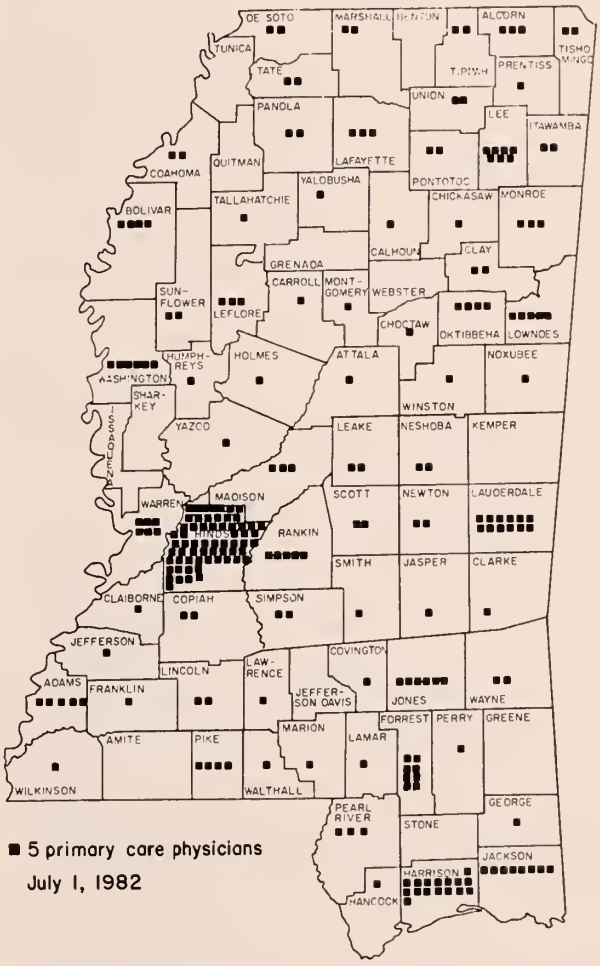

Figure 1

Mississippi has been recognized as a health manpower shortage area for the past decade and state and federal health planning have been directed toward relieving this deficit. The success of these efforts is shown by the reduction of the number of counties

From the Department of Family Medicine, University Medical Center, Jackson, MS.

* The primary care physician was defined by the Millis Commission of the American Medical Association as one who "should usually be primary in the first contact sense. He will serve as primary medical resource and counselor to an individual or family."[2]

FIGURE 2
PRIMARY CARE PHYSICIANS IN MISSISSIPPI
1980

Actual Physician to Population Ratio — 1:2749
Desired Physician to Population Ratio — 1:2000
Primary Care Physicians Needed — 290

that are classified by federal guidelines as health manpower shortage areas from 60 in 1975 to 18 in 1983.† (A ratio of one primary care physician to 3500 people is used in this classification which includes other health manpower factors as well.) This, however, may be misleading as shown by Figure 2, which indicates that large areas of the state have few primary care physicians.

The "National Guidelines for Health Planning" published in the November 25, 1980, Federal Register states that a ratio of one primary care physician per 2000 people is considered adequate but minimum.[3] Using figures published in "Characteristics of Physicians (Mississippi)," December 31, 1979, by the American Medical Association, Center for Health Policy Research, Mississippi had 970 physicians engaged in primary care for a ratio of one physician per 2576 persons (this figure does not include obstetricians).[4] To achieve the recommended ratio of one primary care physician for 2000 population would have required an additional 290 physicians (see Figure 2).

Also to be considered in projecting the supply of primary care physicians is the age of the present physician population, since it must be anticipated that a certain number of primary care physicians will leave active practice each year, due to retirement, disability or death. Statistics from the American Medical Association Center for Health Policy Research study indicate that 28% of physicians in Mississippi were over age 55 in 1980, but that 31% of the primary care physicians and 39% of the family physicians and general practitioners were over 55.[5] Thus as a group primary care physicians and especially general practitioners and family physicians are older than the physician population in general. For the purpose of this study it is assumed that all physicians over age 55 in 1980 will need to be replaced within the next 20 years either by graduates of training programs within the state or from programs in other states. The figures indicate that 342 primary care physicians will be needed to replace over-aged physicians in the next 20 years.

A third factor to be considered in calculating the probable number of primary care physicians needed is population growth. Mississippi, along with other sunbelt states, has been growing steadily in population for the last decade, and it is predicted that this growth will continue during the next 20 years (see Figure 3). Population growth at the rate projected by the Census Bureau will require an additional 290 physicians.[6] Thus it appears that Mississippi will require at least 1022 additional primary care physicians in the next 20 years just on the basis of population factors, existing need and normal attrition. These figures are conservative and make no allowance for loss of younger physicians due to migration, disability, specialization and other factors.

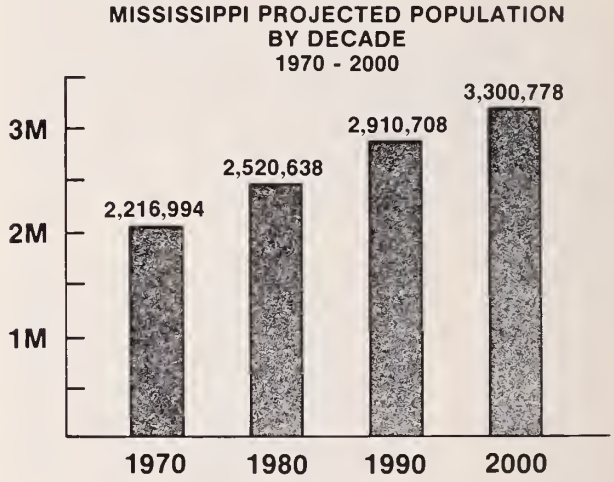

Figure 3

Training programs at the University of Mississippi Medical Center for physicians in primary care (family medicine, internal medicine, and pediatrics) have averaged admitting 39 residents per year for the past five years* (obstetrics and gynecology are not included in these figures) (see Figure 4). These programs will make available 788 physicians trained in primary care medicine in the next 20 years if the same numbers of residents continue to be accepted each year. If this figure is corrected for those going into subspecialties and other areas of medicine such as public health, military medicine and emergency medicine, the figure will be about 590 physicians available (25% loss to other areas of medicine calculated.) Thus, according to these calculations, at least

† Information from the Mississippi Health Care Commission.

* Registrar's Office, University of Mississippi School of Medicine.

FIGURE 4

PRIMARY CARE PHYSICIANS IN MISSISSIPPI
PHYSICIANS ENTERING TRAINING PROGRAMS
1978-1983

	Number	*Average per Year*
Family Medicine	57	11.4
Internal Medicine	103	20.6
OB-GYN	29	5.8
Pediatrics	37	7.4
Total	226	29.4

Source: University of Mississippi Medical Center, Registrar's Office.

432 additional primary care physicians will be needed over the next 20 years to make up the deficit. This means that at least 22 new primary care physicians per year will be needed for the state in addition to those projected to be available. These may come from either expanded training programs within the state or from in-migration of physicians trained elsewhere. At present about two-thirds of the physicians in active primary care practice trained out of state; however, the primary care physicians tend to be older than the physician population as a whole, and many trained before a four year medical school was established in Mississippi. This is especially true of the general practice segment of the physician population which tends to be older than the average physician and which is the only primary care group of physicians actually registering a decline in number in the last ten years. One result of this is that many smaller Mississippi towns and some larger ones are now actively searching for additional primary care physicians. At the time of this writing the Department of Family Medicine has approximately 70 requests from Mississippi villages and towns for family physicians.†

Thus, from this data, it appears that much of Mississippi will continue to need additional and replacement primary care physicians for the next decade, and that we should prepare to train at least part of the additional medical manpower needs within the state. Our figures indicate that at least 20 additional primary care physicians yearly will be needed in addition to those now being trained by existing training programs and at least half of these should be family practitioners who are more likely to locate in small towns. Other measures that may be recommended include a regional or state plan for health services which includes provision for regulating the training positions available to avoid training subspecialists and specialists in numbers that will not be needed. The health plan should also include provision for helping medical graduates trained in the primary care specialties find practice locations where they are needed and a mechanism through a central medical placement office for helping communities evaluate their needs and to contact compatible and suitably trained physicians. Finally, methods of better meeting the medical needs of small towns and rural areas should be explored, such as planning for group practices to furnish essential ambulatory care, emergency, institutional, public health and hospital services for two, three or more communities.[7] ★★★

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† Department of Family Medicine physician recruitment program records.

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The President Speaking

Man's Changing Ideals

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

Back in the simplistic days of the 40's and 50's, it was thought that everything that had ever happened or would ever happen to mankind could be grouped into social, moral or religious, economic, and political categories. Now, in the streamlined 80's, perhaps we need to look and see if this is still true.

With the massive inflation of egos, money, scientific technological advances, and general prosperity, ideals have changed. The idea of a benevolent Father in heaven guiding a nation of people with an authoritarian figure at the head of a family, with religious groups and the wealthy helping the less fortunate began to erode in the 1960's when government stepped in and got involved in social issues. In so doing and in elevating the idea of individual rights and liberties, all authoritarian figures and institutions have been attacked, ridiculed, and debased. The general feeling of self importance thus engendered decreased church membership and attendance to the point where the religious leadership began spending less time teaching the Ten Commandments and became more orientated toward social issues. Things have degenerated to the point where now it seems that it is all right to break any and all of the commandments if it is done in the name of social need. This nation has become so conscious of the rights and liberty of the offender that the government seems to have forgotten the rights of the offended. As an example, recently, a burglar was shot by a victim as he was leaving the house. The robber sued the homeowner and recovered damages. The way things are moving, this sort of episode will soon be covered by workmen's compensation insurance.

Since the beginning of the "Great Society," politics has increasingly dominated economics to the point that the federal government is the largest "employer" or money supplier in many of our counties. With the ever increasing age of our population and the educational standards decreasing to the point where high school graduates often cannot read or write well enough to be employable, those provided for are someday going to outnumber those able to do the providing; and the whole system will topple.

Looking back over our categories, it seems that we can now streamline them by downgrading all except "politics," which is assuming an escalating importance even to the point of dominance. Isn't it amazing that in our attempt to realize individual freedom that the cocoon which man weaves around himself pinches, binds, and stifles more and more each time we place self above country and country above God? ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
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VOLUME XXV, Number 3

MARCH 1984

I Told You So!

One of the most soul-satisfying feelings we can have, I'm sure, whether we admit it or not, is the chance to say — "I told you so!" And I'm feeling pretty soul-satisfied right now! In my periodic harangues about our deteriorating image I guess the money-grubbing facet gripes me the most. We now wait for the ax to fall — to do to us what we refused to do for ourselves. Most observers feel certain that a cap on Medicare fees is inevitable and mandatory assignment quite possible.

I wonder if you happened to see the piece in the *Clarion-Ledger* concerning the wealthy physician needing help in his battle against the tax bill. It was in a "People and Their Money" series. This ENT man in our capital city earned (?) $185,000 and stated that he expected to earn 10% more this year. Wonder how many dusky little ear-drums were sacrificed on his altar of avarice? This in a state where the average per capita income (1982) was $7,798. Thus another niche was blasted in our crumbling image. I fear he was not alone, for the average median income for a physician in 1964 was $28,300 and in 1982 it had soared to $99,500!

Maybe we have a "death-wish," or a masochistic urge to cut our own throats, and it seems to me we are admirably succeeding.

I told you so!

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

JOIN MPAC TODAY

Our Dwindling Resources

We are depleting our soils at an alarming rate. Top soil that in places was at one time three to five feet in depth, is now down to six inches. Nitrogen and minerals must be added in increasing amounts.

Our aquifers are steadily falling and some cannot be replenished in the foreseeable future. Many arid areas, now thickly populated, are totally dependent on them for irrigation. Acid rain is a real hazard, and the extent of its consequences is not yet fully understood. The danger of hazardous waste is increasing and the rationale of nuclear energy is debatable. Our fossil fuels are being exhausted, and the end of our known reserves is in sight.

Now we are concerned about the "green-house affect," the result of atmospheric contamination largely from the burning of fossil fuels, with the predictable warming of the earth surface.

We are reminded of these dangers daily; yet no one reminds us of the cause. Only people cause pollution; only people deplete our resources. How many people can our resources support indefinitely?

We are subsidizing, and in many ways even encouraging, the increasing reproduction of the very segment of our society least able to cope — the segment totally ignorant of the economic picture, or of the consequences of overpopulation.

Unemployment can only increase as technology (computer, robots, etc.) gradually erodes the numbers required in our work force; and unemployment (idleness) is a prime factor in the fostering of social unrest and crime.

Shouldn't society have the right — indeed, doesn't society have the obligation to try to limit the reproduction of those unable to support themselves and requiring total government subsidy.

Who better than the medical profession to encourage this?

W. MONCURE DABNEY, M.D.
Editor Emeritus

COMMENT

A Word of Caution

During the 1970s, virtually all of the commercial insurance carriers abandoned the medical professional liability insurance market when it was no longer a profitable line of business to underwrite. Medical associations in the neighboring states of Alabama, Tennessee, and many other states formed physician-operated professional liability carriers due to a total lack of availability of coverage in the commercial marketplace. Seeing the handwriting on the wall, the Mississippi State Medical Association, by action of its House of Delegates, obtained enabling legislation and formed the Mississippi Medical Fraternal and Educational Society. In 1982, the corporate name was changed to "Medical Assurance Company of Mississippi."

For nearly eight years, Medical Assurance has continued to fulfill its goal of providing medical professional liability insurance for Mississippi physicians at the lowest premium rates possible. The strength of Medical Assurance lies not only in its dependability, but also in its operation by and for Mississippi physicians. Any benefits derived go directly to the policyholders, not to commissioned salesmen or far-flung stockholders. It is no accident that the operating expenses of Medical Assurance are among the lowest of some 30 physician-owned-and-operated professional liability companies now in business in the United States. Medical Assurance is *not* in this line of business to make one or two individuals multimillionaires, as is true of at least one commercial carrier with whom we are familiar.

This open letter to Mississippi physicians is written to inform you that certain commercial carriers are re-entering the medical professional liability insurance market. Additionally, there are other commercial carriers, some located "offshore," who have only recently decided to "dabble" or experiment in the medical professional liability area. Their attempt to solicit your business is founded primarily upon the lure of absurdly low premiums. Their premiums are held down long enough to capture a market share, then drastically increased to pay losses out of future cash flow. In such a volatile market, this strategy is extremely risky under the best of circumstances, both for the company and the physician who is getting the "bargain." Thus, the cut-rate company finds itself in a position in which it is unable to raise premiums fast enough to offset losses. The result can be financial collapse, leaving the bargain-shopping physician without prior acts coverage. To quote Ronald E. Henderson, M.D., president of the Medical Association of the State of Alabama, partaking of this game "is similar to Russian roulette: you don't have much to win, but quite a lot to lose."

Medical Assurance Company of Mississippi will not lower itself to become involved in bidding wars. Medical Assurance offers the lowest premium rates possible, consistent with actuarial reality. Involvement in cutthroat bidding or bait-and-switch marketing gambits would jeopardize the credibility and financial integrity of your company.

Medical Assurance was formed for your protection when a very real threat existed that medical professional liability coverage would become totally unavailable. With the continuing increase in the severity of claims, we have noted that several commercial carriers who had re-entered the market have already "re-abandoned" this line of business. Others have been noted to be at or near financial collapse.

A word of warning is in order for those of you who might be solicited by an unknown carrier offering the bait of suprisingly low premium rates. Think of the extra dimensions of service provided by your own company, run by and for Mississippi physicians. To quote again from Dr. Henderson of Alabama, "liability insurance, properly and professionally based, is designed for long distance and endurance, not the fifty-yard dash. Beware of cut-rate insurance that may well prove to be worse than no insurance at all."

If you are approached by someone with a "bargain" for your professional liability, backed by a carrier with whom you are not familiar, we would recommend that you consult with Medical Assurance before making any professional liability decision which could detrimentally affect your financial security. Thank you for your support of and participation in Medical Assurance Company of Mississippi.

R. Faser Triplett, M.D., President
Medical Assurance Company of Mississippi
P.O. Box 4625
Jackson, MS 39216

Journal MSMA invites your comments, inquiries, and suggestions. Please address correspondence to the Editors, P.O. Box 5229, Jackson, MS 39216.

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LETTERS

To the Editor: (And to the doctors who read Journal MSMA).

If you don't read Ann Landers in your newspaper, you should. Almost daily there are personal problems, very sad indeed. I often wonder what the effect would be if the spouse of the aggrieved could be heard.

In the January issue of the Journal, (The President Speaking, page 14), Dr. Johnson spoke of "The Way Things Were." Very impressive figures, those.

What Whit did not mention was the income of MDs during those times. Figures taken from the AMA's Center for Health Services Research and Development and from the U.S. Department of Commerce show that the average median income for all MDs in the U.S. for 1964 was $28,300. In 1974 it was $51,977. In 1982 (the latest year available) the figure had grown to $99,500.

"Are you better off now than you were then?" I'll bet your nurse is, too.

Walter H. Simmons, M.D.
338 Arapaho Lane
Madison, MS 39110

To the Editor:

You are familiar with the taunting child's verse, "Smarty, Smarty gave a party; nobody came but Smarty, Smarty." Embarrassing for Smarty, wouldn't you think?

Well, I recently attended a dinner meeting sponsored by a pharmaceutical company, and almost nobody came. It, too, was embarrassing — *for the Medical Profession!*

The drug rep had sent out invitations and received 20 positive responses. He had then made arrangements with a local restaurant: table settings for 20; rib eye steaks, salads, baked potatoes, pecan pie for 20; and a bar that would have floated a battleship. At the appointed hour only six physicians appeared. None of the absent fourteen bothered even to phone their regrets.

I realize that their empty seats characterize society's attitude in general, but I also believe that they directly reflect today's somewhat tarnished image of our medical profession. If we have not yet learned rules of etiquette, then let us buy a book. However, if we have merely forsaken the social amenities, then shame on us.

Stanley Hartness, M.D.
314 W. Adams Street
Kosciusko, MS 39090

RECOLLECTIONS

Twenty years ago the March issue of Journal MSMA pictured the opening of the MSMA Emergency Medical Care Unit at the Mississippi State Capitol. The unit, proposed and approved by the House of Delegates the previous year, opened with then-president Dr. John G. Archer of Greenville as first "Doctor of the Day."

That issue also included an article attributing the cordial relationship between physicians and members of the news media for the success of Central Medical Society's first Sabine Oral Polio Vaccine Sunday, which attracted 301,667 persons over the eight county area.

Scientific articles included "Symptomatic Lower Esophageal Ring," by Robert P. Henderson, M.D. of Jackson and "The Morality of Medicine," by John G. Archer, M.D. of Greenville.

Ten years ago the March issue of Journal MSMA announced preliminary plans for the 106th Annual Session. The issue also printed an article noting that health expenditures for the nation in 1973 had reached $94.1 billion, or 7.7% of the Gross National Product.

Among scientific articles published that month were: "Urinary Tract Infections in Childhood," by James E. Keeton, M.D. of Jackson and "Pseudofractures of Osteomalacia," by John Y. Gibson, M.D. of Jackson.

116th Annual Session
May 16-20, 1984

Preliminary Program

Wednesday, May 16
- President's Reception

Thursday, May 17
- House of Delegates
- Reference Committees
- Miss. Foundation for Medical Care
- Medical Alumni Reunions

Friday, May 18
- Fishing Rodeo
- Surgery Plenary Session
- MSMA Auxiliary General Session
- MSMA Auxiliary Luncheon
- Golf Tournament
- Specialty Society Meetings
- Medical Assurance Co. of Miss.
- MSMA Banquet (Willard Scott)

Saturday, May 19
- Fishing Rodeo
- Medicine Plenary Session
- Tennis Tournament
- Specialty Society Meetings

Sunday, May 20
- House of Delegates

Willard Scott to Entertain During 116th Annual Session

Willard Scott, "Today" show weather reporter and noted speaker, will entertain guests at MSMA's annual membership banquet, Friday, May 18, at the Royal d'Iberville Hotel.

Preliminary Plans Announced For 116th Annual Session

The 116th Annual Session of the MSMA will get underway May 16 at the Royal d'Iberville Hotel in Biloxi.

Record numbers of physicians, spouses and guests are expected to attend the five-day session, which offers a unique combination of scientific and business meetings, fellowship events, and special transportation arrangements for day-long excursions to the 1984 World's Fair in nearby New Orleans.

Willard Scott, NBC's "Today" show weather reporter, will entertain at the annual membership banquet on Friday, May 18. Scott, who achieved fame as a radio and television personality, is also noted as an entertaining speaker and has been recognized for his public service efforts.

House of delegates sessions are set for Thursday, May 17 and Sunday, May 20. Special guest Dr. Frank J. Jirka, president of the American Medical Association, will address the delegates. Reference committee hearings are set for Thursday afternoon.

The scientific program begins on Friday, May 18 with the Surgery Plenary Session, planned by the MSMA sections on surgery, EENT, obstetrics-gynecology, pathology, anesthesiology, orthopedic surgery, and urology. The Medicine Plenary Session is set for Saturday, May 19. That program was coordinated by representatives of the sections on medicine, family practice, preventive medicine, pediatrics, radiology, psychiatry, dermatology, and emergency medicine.

Highlighting the scientific program will be presentation of the James Grant Thompson Memorial Lecture on Saturday, May 19. Dr. Phillip Gorden of the National Institutes of Health will speak on "Diabetes Mellitus: What Form Will a Cure Take?" A number of other speakers will make presentations during the two-day scientific program and at meetings of state specialty societies.

Medical Assurance Company of Mississippi will hold its annual meeting on Friday afternoon and the Mississippi Foundation for Medical Care will conduct its annual meeting on Thursday afternoon. Fifteen specialty societies have also scheduled meetings, including the American College of Surgeons/Mississippi Chapter and the Mississippi Academy of Family Physicians.

The annual President's Reception will mark the official opening of the meeting. That event is scheduled for Wednesday evening, May 16. Medical alumni groups will host receptions on Thursday evening.

On the calendar of special activities are the annual two-day fishing rodeo and the golf and tennis tournaments. The MSMA Auxiliary, which will conduct its 61st Annual Session during the week, also has planned a variety of special attractions.

The complete program of the 116th Annual Session will be printed in the April issue of JOURNAL MSMA.

NEW MEMBERS

Brown, Alan Paul, Tupelo. Born Paterson, NJ, May 13, 1943; M.D., Temple University School of Medicine, Philadelphia, PA, 1967; interned Temple University Hospital, Philadelphia, one year; internal medicine residency, Mayo Clinic, Rochester, MN, 1970-71; elected by Northeast Mississippi Medical Society.

Butler, Thomas W., Meridian. Born Athens, GA, Oct. 9, 1951; M.D., Medical College of Georgia, Augusta, 1977; interned University Hospital, Jacksonville, Fla., one year; radiology residency, same, 1978-79; radiology residency, University of South Alabama, Mobile, 1979-82; elected by East Mississippi Medical Society.

Evans, Owen B., Jackson. Born Little Rock, AR, Oct. 23, 1946; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1973; interned Children's Orthopedic Hospital and Medical Center, Seattle, WA, one year; pediatric residency, Vanderbilt University, Nashville, 1976-77; neurology residency, same, 1977-80; elected by Central Medical Society.

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Everett, T. Keith, Meridian. Born Pittsburg, CA, March 29, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University Hospital, Little Rock, AR, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1980-83; elected by East Mississippi Medical Society.

Greer, Willie Earl, Meridian. Born Tylertown, MS, April 17, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Lloyd Noland Hospital, Fairfield, AL, one year; pediatric residency, same, 1970-72; elected by East Mississippi Medical Society.

Hardin, William G., Meridian. Born Jackson, MS, June 2, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Baptist Memorial Hospital, Memphis, TN, one year; internal medicine residency, same, 1979-81; gastroenterology residency, University Medical Center, Jackson, MS, 1981-83; elected by East Mississippi Medical Society.

Makey, David A., Meridian. Born London, England, April 4, 1949; M.D., St. Thomas' Hospital, London, England, 1972; interned Royal Portsmouth Hospital, London, England, one year; surgery residency, Ochsner Foundation Hospital, New Orleans, LA, 1977-80; elected by East Mississippi Medical Society.

Myatt, Ray E., Meridian. Born Hattiesburg, MS, May 24, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and ob-gyn residency, University Medical Center, Jackson, 1979-83; elected by East Mississippi Medical Society.

Phillippi, Francis M., III, Meridian. Born Brewton, AL, Oct. 31, 1951; M.D., University of South Alabama School of Medicine, Mobile, 1978; interned and pathology residency, same, 1978-82; elected by East Mississippi Medical Society.

Raines, Milton R., Meridian. Born Tuskegee, AL, Nov. 19, 1941; M.D., Birmingham Medical College, Birmingham, AL, 1969; interned St. Vincents Hospital, Birmingham, one year; general surgery residency, Lloyd Noland Hospital, Fairfield, AL, 1970-74; diagnostic radiology residency, David Grant USAF Medical Center, Travis AFB, CA, 1976-79; elected by East Mississippi Medical Society.

Randle, Gerald Phillips, Jackson. Born Pine Bluff, AR, Feb. 14, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Memorial Medical Center, Savannah, GA, one year; neurology residency, Vanderbilt University, Nashville, TN, 1975-78; elected by Central Medical Society.

Reid, Kenneth J., Jr., Meridian. Born Mobile, AL, June 18, 1951; M.D., University of South Alabama, Mobile, 1977; interned and pediatric residency, Lloyd Noland Hospital, Fairfield, AL, 1977-80; elected by East Mississippi Medical Society.

Sullivan, Suzanne R., Jackson. Born Fort Riley, KS, April 10, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and anesthesia residency, Ochsner Foundation Hospital, New Orleans, LA, 1980-83; elected by Central Medical Society.

Walker, Elmo L., Jackson. Born Poplarville, MS, June 18, 1919; M.D., University of Texas Southwestern Medical School, Dallas, 1956; interned Mississippi Baptist Hospital, Jackson, MS, one year; elected by Central Medical Society.

Wallace, Mickey P., Jackson. Born Brookhaven, MS, April 23, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned Baptist Memorial Hospital, Memphis, TN, one year; otolaryngology residency, Medical University of South Carolina, Charleston, 1980-83; elected by Central Medical Society.

Watridge, Clarence B., Pascagoula. Born Humbolt, TN, March 1, 1950; M.D., University of Tennessee Center for the Health Sciences, Memphis, 1975; interned Baptist Memorial Hospital, Memphis, TN, one year; neurosurgery residency, same, 1977-81; elected by Singing River Medical Society.

Williams, Ralph E., Meridian. Born Atlanta, GA, Feb. 26, 1953; M.D., Medical College of Georgia, Augusta, 1979; interned Ochsner Medical Foundation Hospital, New Orleans, LA, one year; diagnostic radiology residency, same, 1980-83; elected by East Mississippi Medical Society.

116th Annual Session

May 16-20 Biloxi, MS

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PERSONALS

Robert L. Abney, III, of Jackson has been elected chairman of the Mississippi chapter, American Academy of Pediatrics.

James Achord of UMC conducted seminars in gastroenterology at the Saudi Career Development Department of Aramco Services Company in Saudi Arabia, in January and also attended the executive committee meeting of the American College of Gastroenterology in Atlanta.

Vinod Anand of UMC lectured at meetings of the Delhi Medical Association in New Delhi and the seventh annual Indian Otolaryngologists' Association in Ahmedabad, India.

George Arthur Applewhite announces the opening of his office for the general practice of medicine at 300 Rawls Drive in McComb.

Blair Batson of UMC was an examiner for the American Board of Pediatrics in San Antonio, Texas, in January.

John Bise of Jackson recently attended the 5th International Congress of Laser Medicine and Surgery in Detroit, and also participated in a China/U.S. medical exchange, visiting five medical centers in China, where he delivered papers on colposcopy.

Richard C. Boronow of Jackson is currently serving as the secretary-treasurer of the Society of Pelvic Surgeons and was program chairman for the society's annual meeting in Philadelphia in November. He is president-elect of the Memorial Sloan Kettering Society of Gynecologic Oncologists.

T. K. Brantley of Jackson has been certified by the American Board of Emergency Medicine.

Edgar Draper of UMC was an examiner for the American Board of Psychiatry and Neurology in Houston, Texas, in January.

James D. Fly announces the opening of his office for the practice of ophthalmology at Suite 510, 971 Lakeland Drive in Jackson.

William R. Ford of Columbus has been elected a senior member of the American Institute of Ultrasound in Medicine.

James Hardy of UMC attended the president's dinner of the American Surgical Association in Pittsburgh, Pennsylvania, recently.

Milton Kramer of UMC was an examiner for the American Board of Psychiatry and Neurology in Houston, Texas, in January.

Herbert Langford of UMC recently presented a paper at a meeting of the Association for the Advancement of Behavior Therapy in Washington, DC, and presented a paper at the annual meeting of the Southern Society for Clinical Investigation in New Orleans.

R. R. Lowe, Jr. of Jackson has been certified by the American Board of Emergency Medicine.

William C. Mayfield, Jr. of Jackson has been elected chief of staff of St. Dominic-Jackson Memorial Hospital. Other officers are chief-elect Ben McCarty and secretary Henry B. Tyler.

Connie McCaa of UMC presented seminars at Mississippi State University in Starkville recently.

Lynn B. McMahan of Hattiesburg announces the association of Wayne B. Beyer for the treatment of diabetic eye disease, macular degeneration, retinal detachment, and glaucoma.

John Morgan of McComb recently was appointed by the Pike County Board of Supervisors to the Board of Trustees, Southwest Mississippi Regional Medical Center.

Bob Myers announces the opening of his office for the practice of adult and pediatric urology at the Physicians Office Unit in Starkville.

Norman Nelson of UMC spoke at a recent meeting of the Rotary Club of Oxford.

Howard Nichols of UMC was an examiner for the American Board of Pediatrics in San Antonio, Texas, recently.

William L. Pace of Hattiesburg has been named a diplomate of the American Board of Obstetrics and Gynecology.

Tom Price of Starkville spoke at a recent meeting of the Starkville Kiwanis Club.

Joe Ross, Jr. of Vicksburg was appointed by Gov. Bill Allain to the state lay Board of Education.

D. K. Stone of Jackson has been certified by the American Board of Emergency Medicine.

M. J. Stout of Jackson has been certified by the American Board of Emergency Medicine.

L. D. Turner of Crystal Springs was recently honored at a special dinner, where patients and friends

expressed thanks for his many years of dedicated service.

PAUL D. VANLANDINGHAM has associated with Jackson Medical Associates, P.A., 1600 North State Street, for the practice of internal medicine.

W. W. WALLEY of Waynesboro recently received the Distinguished Service Award of the Wayne County Chamber of Commerce.

LAMAR WEEMS of UMC recently spoke at the medical staff meeting of the Northwest Mississippi Medical Center in Clarksdale.

DEATHS

AKIN, ROBERT M., Hazelhurst. Born Williamson County, TN, 1909. M.D., University of Tennessee College of Medicine, Memphis, 1951; interned Methodist Hospital, one year; member of South Central Medical Society; died Dec. 27, 1983, age 74.

FRASER, BLAIR F., Water Valley. Born Canada, June 22, 1946; M.D., Dalhousie University, Halifax, Nova Scotia, 1976; interned Victoria General Hospital and Camphill Veterans Hospital, Halifax, Nova Scotia, and St. John General Hospital, St. John, New Brunswick, one year; member of North Mississippi Medical Society; died Feb. 3, 1984; age 37.

FRIDGE, HARRY G., Hattiesburg. Born Sanford, MS, Aug. 6, 1909; M.D., Emory University, Atlanta, GA, 1934; interned Madison General Hospital, Madison, Wisconsin, one year; member of South Mississippi Medical Society; died Jan. 31, 1984, age 74.

Medico-Legal Brief

$12.47 Million Award Upheld

A $12.47 million malpractice award was upheld, but the patient's attorney's fee should be lowered from $4.4 million to $1.5 million, a Florida appellate court ruled.

A 30-year-old auto accident victim was taken to a hospital and placed on a respirator. The respirator malfunctioned, and before the hospital staff discovered the malfunction, irreversible brain damage occured. She was half-blind, hopelessly bedridden, and racked with pain, but she could recognize people and respond to sounds and touch.

In an action against the hospital and the Florida Patient's Compensation Fund, a jury awarded the patient $12.47 million. The trial court awarded attorney's fees of $4.4 million.

On appeal, the jury verdict was affirmed. The evidence showed that the patient had a 40-year life expectancy and required nearly $200,000 worth of medical care each year. The court declared unconstitutional several statutes that limited liability of the hospital to $100,000 per claim and that limited the Patient's Compensation Fund to pay out judgments at the rate of $100,000 per person per year until the claim was paid in full.

The court upheld the statute that provided for reasonable attorney's fees, but said that the award of $4.4 million was not reasonable under the circumstances. The court said that the trial court relied too heavily on the contingent fee arrangement between the patient and the attorney instead of examining the reasonableness of the award. The court said that $1.5 million was a reasonable amount of attorney's fee for the case. — *Florida Medical Center, Inc. v. Von Stetina,* 436 So.2d 1022 (Fla.Dist. Ct. of App., Aug. 10, 1983; rehearing denied, Aug. 30, 1983)

Editor's Note: The Florida Patient's Compensation Fund has advised that it is not currently selling any coverage and that hospitals have dropped out of the fund. The fund was created in 1975 by the state legislature to provide optional, unlimited coverage for claims exceeding $100,000 to physicians and hospitals.

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CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds

MEPROBAMATE: Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity

GI: Nausea, vomiting, diarrhea

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate:mebutamate and meprobamate: carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura

OTHER: Exacerbation of porphyric symptoms

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur

At levels greater than 20 mg percent, more fatalities than survivals can be expected

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption

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PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

BOARD CERTIFIED FAMILY PRACTITIONER seeks location in Jackson or Greenville area with established group beginning August 1, 1984. Contact Hernando C. Payne, M.D., 1557-A Eglin Way, Washington, DC 20336.

NATIVE MISSISSIPPIAN completing pediatric residency in July 1984 seeks location in state. Contact Tom Ireland, M.D., 3516 Casawoods Lane, Clarkston, GA 30021; (404) 296-2940.

BOARD CERTIFIED internal medicine physician seeks location for small rural practice. M.D. from Johns Hopkins University. Contact Edwin B. Struve, M.D., 29 Dellwood Avenue, Chatham, NJ 07928.

ANESTHESIOLOGIST seeks practice location. Box A, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

GENERAL SURGEON seeks relocation in Mississippi. Box S, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

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Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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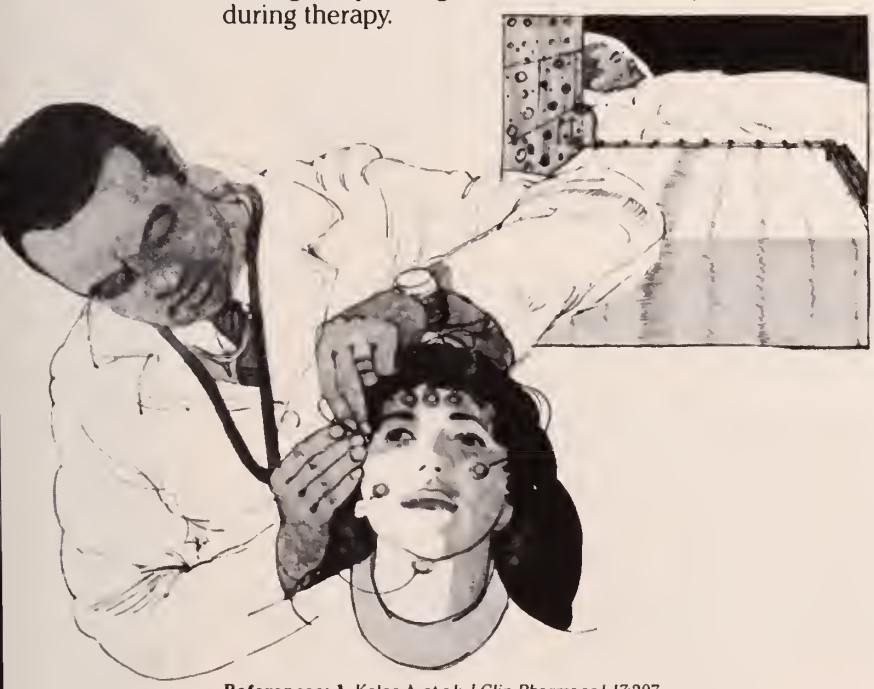

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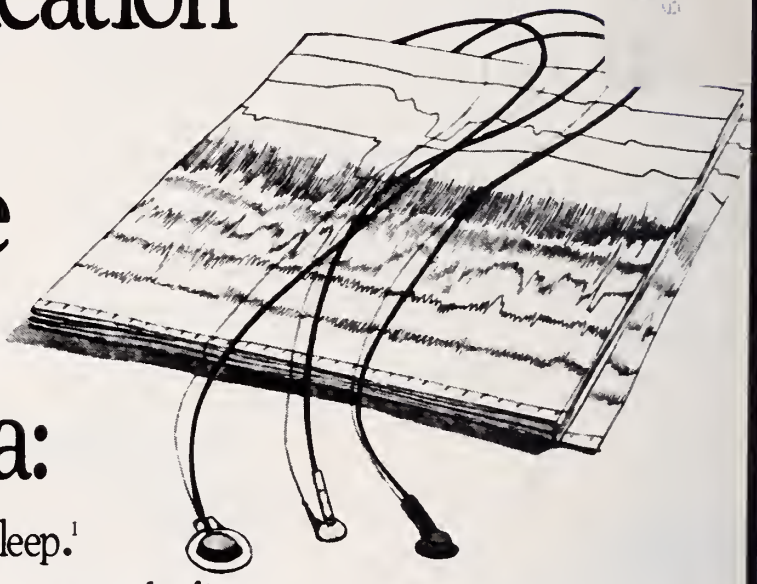

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April 1984

JOURNAL of the MISSISSIPPI State Medical Association

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Physical Exercise and Health: A Review Study

Diagnostic Ultrasound Usage In Pregnancy — A Recent Assessment

Program: 116th Annual Session

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NEWSLETTER

April 1984

Dear Doctor:

Opinions on four diagnostic procedures that are controversial in the medical community were released by the AMA's Diagnostic and Therapeutic Assessment (DATTA). Four panels of physicians, in separate studies, concluded that:

> Diaphanography (transillumination of the breasts) for cancer screening is to be considered investigational until adequately controlled comparisons with mammographic screening are reported;
>
> Implanted electrospinal stimulator for scoliosis is to be considered investigational until data confirms it is as effective as the Milwaukee Brace;
>
> Treatment of childhood leukemia after a second or later relapse with total body irradition and bone marrow transplantation is an established procedure in those patients not successfully controlled by chemotherapy;
>
> In the absence of controlled studies, no consensus could be reached about the safety and effectiveness of gastric bypass or gastroplasty in the management of morbid obesity.

MSMA's Board of Trustees last month went on record in support of the AMA's call for a one-year, voluntary freeze on physicians' fees. The Board also urges physicians to continue to take into account the financial circumstances of each patient, and to accept reduced fees when warranted.

Plans for the 116th Annual Session in Biloxi are outlined in this issue. MSMA members planning to attend are encouraged to make hotel reservations early. Due to the World's Fair in New Orleans, coast hotels may be accomodating larger numbers of tourists. Special guests during the May 16-20 meeting will include AMA president Dr. Frank Jirka, who will address the House of Delegates, and television personality Willard Scott, who will speak at the annual banquet.

Among proposals the House of Delegates will consider during the Annual Session is a recommendation from the Board of Trustees to renovate and expand the MSMA headquarters office. The proposed expansion would meet growing needs for space and provide additional space to be leased to Medical Assurance Co. of Miss. and the Mississippi Foundation for Medical Care. The present structure was built in 1956 and was last renovated in 1970.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

Counsel to Authors

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DATELINE

Herpes Drug Controls Tumor

Chicago, IL - Acyclovir successfully cleared a potentially fatal skin tumor, according to an article in the March 23 JAMA. The case involved a woman suffering from mycosis fungoides. Standard anticancer drugs were the initial therapy, but when herpes eruptions appeared, acyclovir was administered. Both conditions cleared. When tumors recurred, a second course of acyclovir again resulted in regression.

UM Institute Patents Poison Ivy Preventive

University, MS - A patent has been awarded to the University of Mississippi for compounds that will prevent allergic reactions to poison ivy, poison oak, and poison sumac. Fifteen years of work by the Research Institute of Pharmaceutical Science investigators led to the development of the compounds, already licensed to a private drug company which has begun clinical trials.

AMA Sues HHS On Baby Doe Regs

Chicago, IL - The AMA filed suit seeking to have the final version of the controversial "Baby Doe" regulations declared invalid. The suit contends: that the Dept. of HHS is improperly interjected into treatment decisions; that the regulations are beyond statutory authority; that the Secretary of HHS failed to conduct an adequate factual investigation; and that parental constitutional rights are violated.

AMA Urges Separate Department of Health

Chicago, IL - The AMA has renewed its call for a separate U.S. Department of Health headed by a physician. The testimony came before the Congressional Panel on Social Security Organization, which is considering splitting the Social Security Administration from the Dept. of HHS. The AMA also suggested that the Health Care Financing Administration be made a part of the proposed Department of Health.

Near Drowning Patients May Be Salvageable

Dallas, TX - Persons submerged in cold water may go for as long as 30 minutes without breathing and recover with no brain damage, according to an article in the April Annals of Emergency Medicine. Aggressive treatment both at the scene and in the hospital is recommended, even in those who initially appear dead, the authors state. A recent study showed that 19% of near-drowned patients recovered completely.

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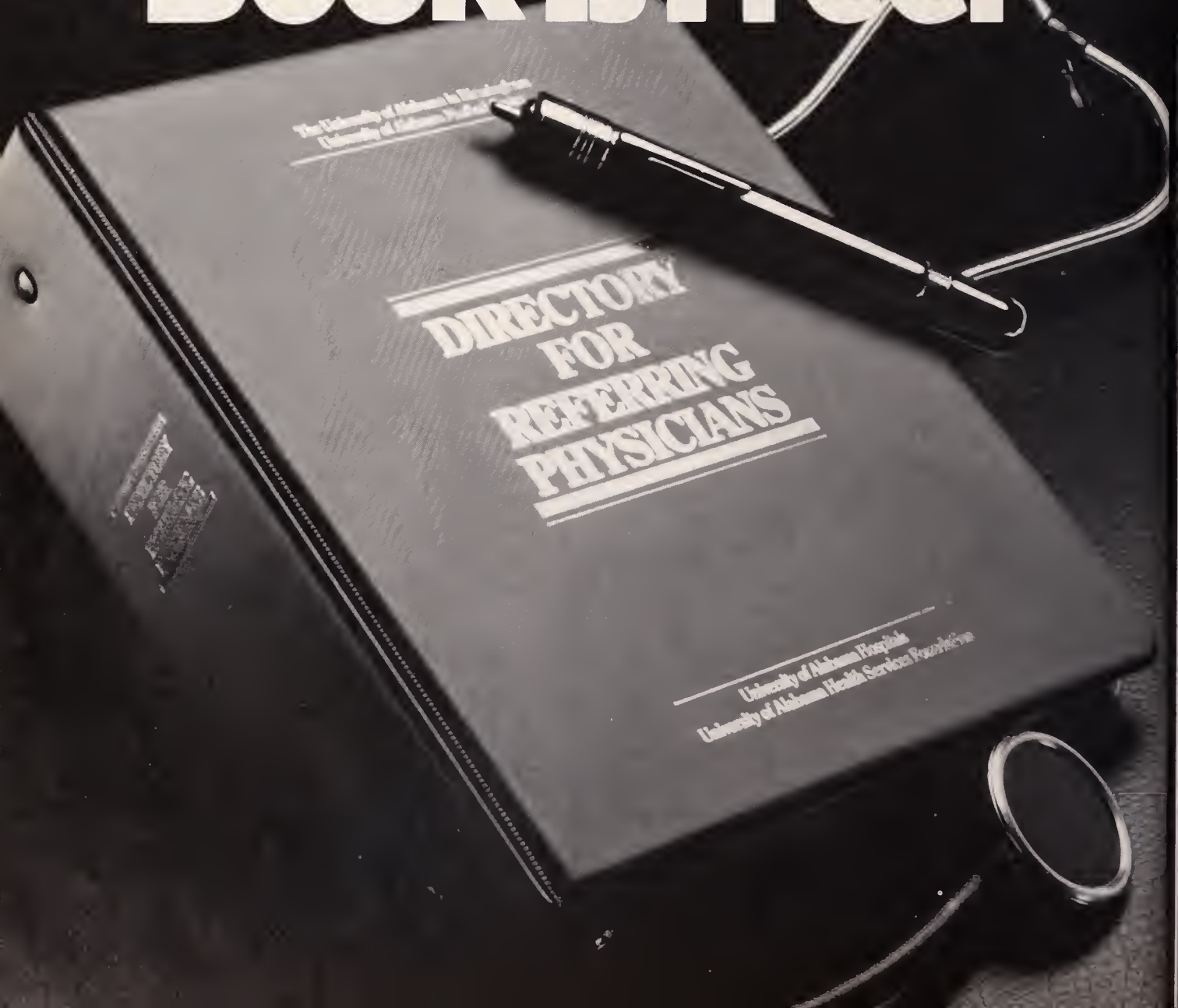

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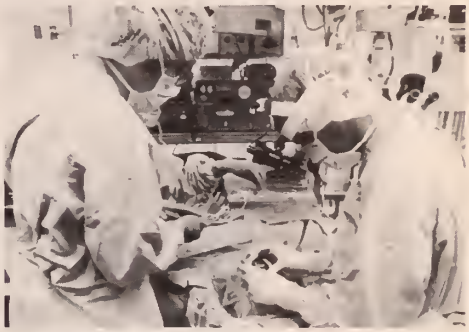

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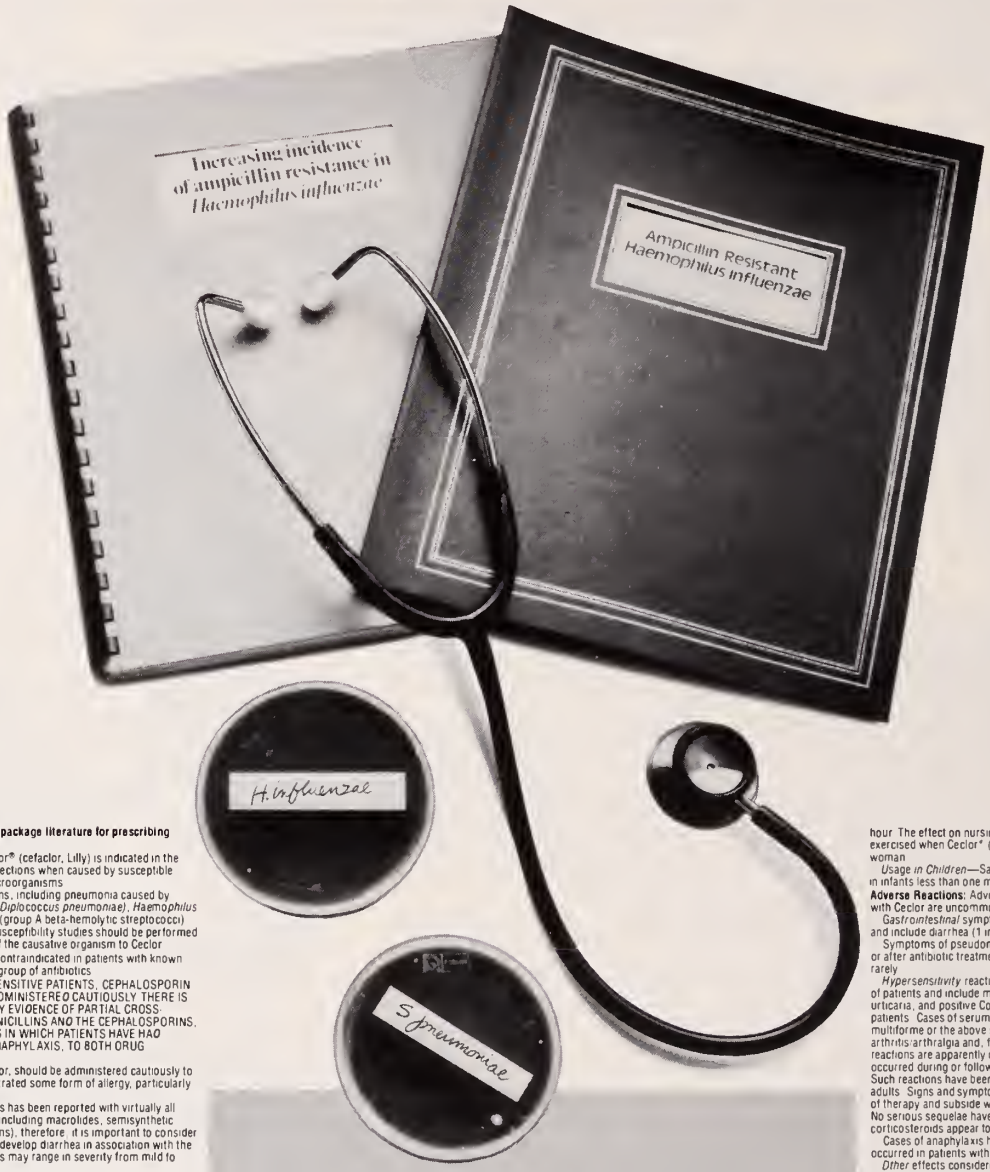
An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References:

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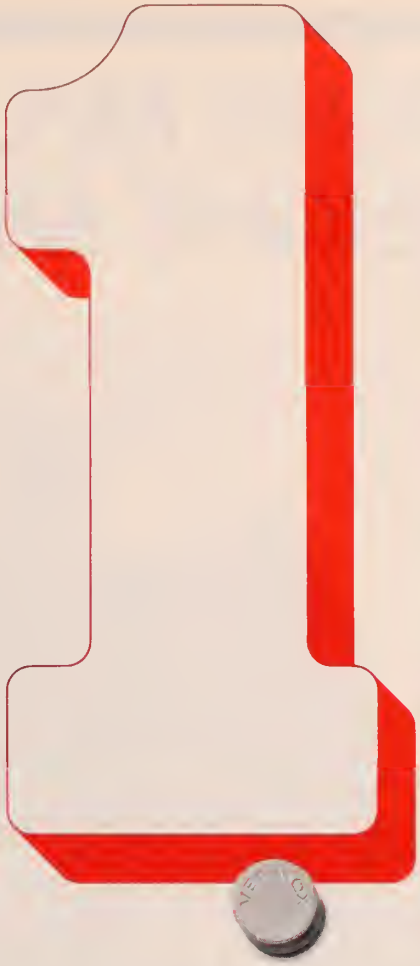

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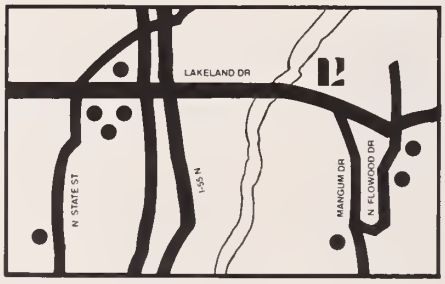

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JOURNAL OF THE MISSISSIPPI MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Endoscopic Sclerotherapy of Esophageal Varices

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Esophageal sclerotherapy was first performed in the 1930s, but was discontinued when portacaval shunt surgery was introduced as the "definitive procedure" for bleeding esophageal varices. However, the high morbidity and mortality associated with portacaval shunt, especially emergency shunts, has led to a renewed interest in esophageal sclerotherapy over the past decade. The authors report that at Parkland Memorial Hospital in Dallas over a two-year period, there have been 429 patients with upper gastrointestinal bleeding. Of these, 108 were secondary to esophageal varices, with 35 adult patients undergoing sclerotherapy. Of these, approximately one-fourth had their bleeding successfully controlled with sclerotherapy and one-fourth failed to have their bleeding controlled. The remaining half of the patients died from other causes, but their bleeding was controlled at the time of their death.

BLEEDING FROM ESOPHAGEAL VARICES has the highest mortality rate of all hemorrhages of the GI tract. It is reported to be about 50% for the initial episode of hemorrhage. Hepatic function which is already impaired deteriorates further with shock, massive blood transfusions, and an increased protein load in the gut, thus leading to hepatic failure and death.

The short-term management objective for bleeding esophageal varices is to gain primary control of the hemorrhage. Our currently recommended approach to upper gastrointestinal bleeding in cirrhotic patients is early endoscopy after the patient has been stabilized. If acute bleeding from esophageal varices is found on endoscopy, injection sclerotherapy is performed at the time of the initial endoscopy. In addition, peripheral venous vasopressin is given. If the patient continues to bleed, then one should proceed to balloon tamponade and possibly emergency portacaval shunt. On the other hand, if the patient stops bleeding, consideration is given to elective portacaval shunt surgery, a long-term sclerotherapy program, propranolol therapy, or observation alone.[1, 2]

If only nonbleeding varices are seen, then one should observe and consider elective sclerotherapy, elective shunt, or continue to observe. If sources other than varices are seen such as ulcers, gastritis or a Mallory-Weiss tear, they should be managed appropriately.

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Portacaval shunt surgery. This has not lived up to the expectations that physicians had when it was introduced. In most series emergency portacaval shunting carries an overall mortality rate of 42% (54% mortality in those with ascites).[3] In addition, encephalopathy is observed postoperatively in 32% of patients. The elective therapeutic shunt on the other hand, has a surgical mortality rate of about 10%. This almost acceptable risk can be kept low

only when a preoperative selection of patients is carried out. The ideal patients are Child's class A and A/B but they compose only about 20% of all those patients admitted for the treatment of variceal bleeding. That leaves 80% of patients with advanced hepatic insufficiency who are not suitable for therapeutic shunting.[4]

The newer distal splenorenal shunt of Warren and Zeppa was designed to selectively decompress esophageal varices without compromising hepatic blood flow.[5] However, this procedure has not improved survival although there may be a lower incidence of encephalopathy in the first few years post-shunt compared to the other shunt operations. Because of the increasing dissatisfaction with shunting procedures, sclerotherapy is now being reevaluated.

Esophageal Sclerotherapy. The first documented use of injection sclerotherapy for bleeding esophageal varices was in 1936, by Crafoord and Frenckner.[6] Despite the demonstrated efficacy in controlling acute variceal hemorrhage, sclerotherapy failed to gain widespread acceptance. This was probably due to the hopes in portasystemic shunt surgery 20 to 30 years ago. The rebirth of esophageal sclerotherapy started with Johnson and Rogers in 1973.[7] They showed a substantially improved in-hospital survival of all patients undergoing sclerotherapy, irrespective of the severity of the underlying liver disease. In 117 patients, they were able to control variceal hemorrhage in 93%, with a mortality rate of less than 18%.

In 1980, Clark et al[8] reported a randomized clinical trial of repeated injection sclerotherapy for the prevention of further hemorrhage from esophageal varices. In the control group rebleeding occurred in 19 (68%) of the patients over a mean follow-up of nine months. Whereas only 12 (33%) of the patients receiving sclerotherapy experienced rebleeding in the same follow-up period. One year survival in the control group was 46% vs 65% in the sclerotherapy group.

A second randomized trial was done by MacDougall.[9] Patients were randomized to 56 in the control group and 51 in the sclerotherapy group. Sclerotherapy was performed under general anesthesia with a flexible fiberoptic endoscope. Sessions of injection were continued approximately every 3 weeks until all varices were sclerosed. There were 22 deaths in the control group with 17 being secondary to variceal bleeding. This was significantly greater than in the sclerotherapy group in which only 4 of the 11 deaths resulted from variceal hemorrhage and 3 of the 4 deaths were before obliteration of the varices. There was only one death due to the procedure, caused by esophageal perforation. The two-year survival was statistically better in the sclerotherapy group (75%) than the control group (58%). These results are felt to demonstrate that sclerotherapy should be continued until esophageal varices are obliterated. The complications encountered in this study were perforation, ulcer, and stricture in 1, 3 and 4 patients, respectively.

Several other studies on the control of acute variceal hemorrhage by injection sclerotherapy have been reported since 1973. In these studies acute variceal hemorrhage was controlled by sclerotherapy in 79%-96% of bleeding episodes. These results may be impressive.[10] However, one must be aware that these were not all well controlled, randomized studies and thus are open to criticism.

Case Report

A 36-year-old Latin American female, Jehovah's Witness, was diagnosed as having primary biliary cirrhosis in 1981. She presented to the Parkland emergency room with major hematemesis in January 1982. Bright red blood was aspirated per nasogastric tube. Admission laboratory testing revealed a hematocrit of 28%, a prothrombin time of 12 sec (normal < 11), total bilirubin of 4.9 mg/dl (< 1.5), SGOT of 129 U/l (<40), and alkaline phosphatase of 455 U/l (< 95). Due to her religious beliefs she refused to receive blood products and was resuscitated with crystalloid solutions. Endoscopy revealed prominent esophageal varices with a fresh clot on one varix. She underwent injection sclerotherapy with sodium morrhuate at the initial endoscopy. She did well and was discharged after one week without complications.

She then entered into a chronic sclerotherapy program and to date has received 11 injection courses with minimal complications. In March 1982, her third sclerosing was complicated by transient chest pain, bronchospasm, and fever with a normal chest radiograph and complete blood count. In April 1982, during her fifth session, she developed a small Mallory-Weiss tear secondary to retching during the procedure, but there was no significant bleeding. In July 1982, five months after her first sclerotherapy, there were no esophageal varices present. In both February and April 1983, she had two small varices which were sclerosed. In June of 1983, again no varices were seen. Thus far, this patient is doing well on maintenance sclerotherapy and has not rebled. However, this does not prove that the natural history of the patient would not have been the same without sclerotherapy, or that she may

not bleed again; nevertheless, it seems likely that sclerotherapy was of benefit.

Materials and Methods

At Parkland Memorial Hospital at Dallas, a fiberoptic endoscope is used with topical anesthesia and IV sedation. A "homemade" flexible needle is preloaded in the biopsy channel of the endoscope and varices are injected with 2 ml of 1% sodium tetradecyl sulfate up to a total of 20 ml during each procedure. Injections are carried out 2 or 3 times within the first month and subsequently at 1 to 4 month intervals until all varices have disappeared.

Results

Use of sclerotherapy in our hospital started in April 1981. During the first two years (April 1981-March 1983), there have been 429 patients with upper GI bleeding. Of these, 108 were secondary to esophageal varices with 35 adults undergoing sclerotherapy.

Of the 35 adult patients, 15 had their bleeding controlled by sclerotherapy but died of other causes, 10 were considered successes without rebleeding, 9 were failures and rebled, and 1 patient was lost to follow up (see Table 1). In essence, one-half died from other causes, one-fourth were successes, and one-fourth were failures. However, one should be aware of the fact that all patients with gastrointestinal bleeding are admitted to the surgery service at Parkland Hospital. If the patient is a shunt candidate, the surgeon usually elects to perform a shunt rather than refer the patient for sclerotherapy. Thus, our sclerotherapy patients tended to be more critically ill and without other treatment options which may have affected our data.

Of the patients who died from other causes, seven (47%) died from sepsis, three (20%) from liver failure and one each from pneumonia, cor pulmonale, post-shunt, small bowel infarction, and cardiac arrest.

Ten of the 35 patients were considered successes. In nine patients there was disappearance of varices or no rebleeding after a mean of five treatments. One patient underwent elective shunt after two treatments.

Nine of the 35 patients were sclerotherapy failures. One patient's sclerotherapy was complicated by esophageal perforation leading to his death. Three patients rebled after one session of sclerotherapy and died. One patient rebled after one course of sclerotherapy and received an emergency shunt and died postoperatively. Another patient rebled after two courses of sclerotherapy, received an emergency shunt, and subsequently developed chronic encephalopathy. Two patients rebled after two courses of sclerotherapy and received an emergency shunt. One patient rebled after 10 courses of sclerotherapy, received an emergency shunt, and died postoperatively.

In the Parkland experience, only one complication, esophageal perforation, has led to a patient's death (see Table 2). Other complications have included fever, increase in the white blood cell count, transient ulcer, transient stricture formation, ulcer with adjacent gangrene, and a Mallory-Weiss tear.

TABLE 1
SCLEROTHERAPY RESULTS

1. Death from other causes *(15 out of 35, 43%)*	
Sepsis	7
Liver failure	3
Mg citrate aspiration	1
Cor pulmonale	1
Postoperative (after elective shunt)	1
Small bowel infarction	1
Cardiac arrest	1
2. Successes and "cures" *(10 out of 35, 29%)*	
Disappearance of varices, no rebleeding in 9 patients after a mean of 5 treatments (range 1-10 ScRx session)	
One patient underwent elective shunt after 2 treatments	
3. Sclerotherapy failures *(9 out of 35, 26%)*	
Esophageal perforation - death	1
Rebleeding - death	3
Rebleeding after ScRx (×2) - Emergency shunt - Postop death	1
Rebleeding after ScRx (×2) - Emergency shunt - Chronic encephalopathy	1
Rebleeding after ScRx (×2) - Emergency shunt	2
Rebleeding after ScRx (×10) - Emergency shunt - death	1

TABLE 2
COMPLICATIONS OF SCLEROTHERAPY
35 ADULT PATIENTS

Esophageal perforation - death	1
Transient ulcer	5
Transient stricture	3
Ulcer with adjacent gangrene	1
Mallory-Weiss tear	1
Fever and - WBC in many cases	

Discussion

Acute variceal hemorrhage in patients with cirrhosis and poor liver function carries a mortality rate of greater than 50%. The treatment of variceal

hemorrhage has remained controversial through the years as new modalities have come to the forefront, such as sclerotherapy, surgical shunt, balloon tubes, obliterative angiotherapy and long-term propranolol. The portosystemic shunt has been a disappointment in that it has not significantly improved survival and often leaves the patient encephalopathic after surgery. In addition, poor risk patients (Child's class C who cannot be improved to A or B states) are not even considered for a portacaval shunt because of the prohibitive mortality rate. In contrast, sclerotherapy can be performed on poor risk patients with a lower morbidity and mortality rate. Without any patient selection, Johnston and Rogers,[7] in 1973, found mortality to be reduced to less than 20%. Since these initial trials, sclerotherapy has evolved from the use of a rigid endoscope under general anesthesia to a flexible fiberoptic endoscope with local anesthesia and intravenous sedation. Injection sclerotherapy seems to have several advantages over other means of controlling variceal hemorrhage. Any accomplished endoscopist can learn the technique of sclerotherapy and the varices may be readily sclerosed once the source of hemorrhage has been established at the time of the initial endoscopy. Neither an operating room nor an anesthesiologist are required and the patient is not exposed to the potentially deleterious effects of general anesthesia. It appears ideal for patients who are not surgical candidates for whatever reason, but it can also serve as a temporary measure for patients who may ultimately be surgical candidates.

A prospective, randomized study of cirrhotic patients with bleeding esophageal varices by Orloff et al[3] reported a survival rate of less than 5% in the medically treated group. Several controlled clinical trials of sclerotherapy for variceal hemorrhage have demonstrated increased long-term survival in the patient; one year survival of 65%[8] and two year survival of 75%.[7]

At Parkland Hospital over our two-year experience, approximately one-fourth of all patients admitted with variceal bleeding could be successfully treated with sclerotherapy, one-fourth failed to be controlled by sclerotherapy and rebled, and half of the patients died from other causes, with their bleeding controlled at the time of death. Considering the poor prognosis of patients with variceal hemorrhage and the number of nonsurgical candidates referred for sclerotherapy at Parkland, a success rate of 29% is encouraging. It needs to be emphasized, however, that our data are the result of an open clinical trial. Several controlled clinical trials are now being undertaken in the United States. Until all these results are in, sclerotherapy should still be looked upon as an investigational procedure. Those who perform it need to record their results with great care and accuracy.

In conclusion, esophageal sclerotherapy may not replace portosystemic shunt surgery but is certainly a viable alternative, especially in nonsurgical candidates. Although more and longer observations are necessary, esophageal sclerotherapy appears to be a simple, relatively safe, and effective treatment modality for bleeding esophageal varices. ★★★

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Physical Exercise and Health: A Review Study

S. DEAN MOSTAFA, M.D., H. LEON GARRETT, ED.D., and ROBERT A. FREEMAN, PH.D.
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CONCERN FOR PHYSICAL EXERCISE and its influence on health status has been emphasized in many studies recently. More and more investigations point to the preventive role of exercise on aging, cardiovascular disease and diabetes, and its role in promoting general good health. Yet, there are some contradictory issues about the various effects of physical exercise. The purpose of this manuscript is to review the existing literature to examine these issues and to explore the possibilities of further research about the efforts of the physical exercise.

In support of jogging Levin[1] stated that "I can speak from extensive personal experience, 60 miles of running during an average week and seven completed marathons . . . the most obvious of these are such things as the satisfaction of feeling active and in good condition, the enhancement of health and possibility of prolonging life, the relief of emotional tension. . . . "

The aging process reduces blood vessel elasticity, and jogging does delay this trend. Jogging helps to develop central circulation as a generator of peripheral blood flow. Also, jogging promotes an increased mean transit time through the peripheral capillary bed which may result in enhanced tissue oxygenation.[2] At least a portion of the changes that are usually attributed to aging is in fact caused by disuse. Numerous studies have shown that the maximum oxygen consumption declines with age, at a rate of about 1% per year.[3] DeVries[4] has shown that a program of physical exercise markedly alters this decline. Koivisto and his colleagues[5] refer to a greater shift from carbohydrate to fat utilization during exercise among athletes as compared to sedentary controls. Muscle mass increases with physical exercise and vascularization increases, ie, a larger muscle plasma membrane area is exposed to glucose. This would clarify the improvement in blood glucose tolerance.[6] Randle and Smith[7] refer to hypoxia as known to have an insulin-like effect on membrane transport. Platelet aggregation was strikingly reduced following a conditioning exercise program designed for the cardiac rehabilitation of seven post-infarction men.[8] Physical exercise also decreases the rate of sodium reabsorption in kidneys with a lowering effect on blood pressure.[9] It was concluded that different forms of exericse as in training athletes, ballet and classical dance, jogging and others are equally effective modalities for improvement of cardiovascular fitness.[10, 11, 12]

Foster and his colleagues[13] recommended the warm-up and avoidance of sudden strenuous exercise. Another finding suggested that during successive trials of all out work an increase in the interval of the rest period results in more total work performed and increased efficiency.[14] Physical exercise improves coordination, generates a feeling of well being,[15, 16] improves ability to sleep, produces improvement in tolerance of psychological stress,[17, 18] and contributes to decreased stress hormones, increased vital capacity,[19] and decreased smoking.[15, 19, 20] Physical exercise brought about significant increases in fitness scores.[15, 16, 22, 23] Exercise programs produced significant increases in $\dot{V}O_2$ max. intake in many studies.[15, 16, 17, 24, 25, 26]

Haymes and colleagues[21] reported few differences in thermal and metabolic responses to exercise in cold (5C°) and neutral environments (24C°) between men and women with similar $\dot{V}O_2$ max. intake in many studies.

Many studies indicate significant changes in high density lipoprotein-cholesterol (HDL-C) as a result of more intense physical activity.[17, 22, 27, 28-31] On the other hand, no important positive changes in HDL-C resulting from physical exercise have been reported in some studies.[19, 32-34] Beneficial changes in decreased low density lipoprotein-cholesterol (LDL-C) have been associated with physical exercise.[9, 16, 28, 35] Similar beneficial changes reported decreased very low density lipoprotein as a

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result of physical exercise in both animals and men.[9, 16, 30, 35-37]

Exercise produced significant reduction in the level of triglyceride and total cholesterol in many studies.[6, 9, 15, 20, 25, 28, 31, 36-43] Other studies[26, 32, 33, 44] show that physical exercise fails to alter levels of triglycerides and total cholesterol.

In summary, physical exercise increased high density lipoprotein-cholesterol and decreases very low density lipoprotein, triglycerides and total cholesterol in many studies.[9, 36, 37]

Wood and his colleagues[28] and other studies[6, 15, 17, 20, 24, 25, 45] reported significant reduction in body fat through physical exercise. Smith and Munns[46] and other investigations[2, 22, 41, 42] show similar reduction in the skin folds (at the triceps, subscapular, and suprailiac muscles). Few studies show that physical exercise has no effect on body fat[9, 18] and skin fold thickness.[47]

There was a significant reduction of relative body weight resulting from exercise in many studies.[9, 17, 24, 25, 38-40, 42, 43, 48] Other investigations,[18, 26, 29, 47] however, do not show any response.

Many studies[9, 20, 42, 43, 46, 48, 49] indicate that physical training lowers systolic and diastolic blood pressure. Most participants in physical training programs show significant reduction in resting heart rate.[17, 25, 46, 50] Only one study[58] reported an increase in the heart rate.

Many investigations raise the possibility of improved myocardial vascularity and enhanced collateral circulation.[15, 18, 35, 37] Studies among humans failed to show any substantial increase in collateral circulation or growth of the coronary vasculature, using coronary arteriography. However, the current diagnostic techniques may not yet be sensitive enough for detecting these changes in vascularity of the heart.[18]

Programs of exercise training have a decreasing effect on platelet aggregation,[8] ectopic cardiovascular complication[3, 15, 16, 51] and an increasing effect on the lumen of coronary arteries[16, 35] and fibrinolysis.[16] Also, there are contradictory studies on the effects of physical training on sudden death.[16, 52, 53, 54]

Data show that exercise can be effective in lowering blood glucose[20, 40, 46, 55-58] insulin requirement[59, 60] and plasma insulin.[6, 9, 18, 55] On the other hand, it improves insulin response,[55] body sensitivity to insulin,[5, 6, 9] glucose tolerance[6, 42, 48, 59] and insulin binding to receptors.[5, 9]

Gillespie and his colleagues[17] reported a significant reduction in levels of tension anxiety, anger/hostility, fatigue/inertia and significant increase in the rigor activity as a result of exercise. No effects on depression and confusion have been attributed to physical exercise.

There is still a need for documentation in human beings, similar to that in animals, about the effect of exercise in improving myocardial vascularity and enhancing collateral circulation. Contradictory studies on the effect of physical training on sudden death require further investigation. ★★★

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SPECIAL ARTICLE

Radiologic Seminar CCXXXVII: Diagnostic Ultrasound Usage in Pregnancy — A Recent Assessment

SANDRA A. RHODEN, M.D.
Jackson, Mississippi

RECENTLY THE NATIONAL TELEVISION MEDIA carried reports to the public concerning the utilization of ultrasound in pregnancy. The reports were based on a news release dealing with the National Institutes of Health Consensus Development Conference Consensus Statement.[1] Since some patients have seen or heard about this, it was felt that a condensation of the statement would be useful to physicians who might be questioned by patients. The following is the author's condensation of how that statement came to be and what it contained.

Report of NIH Conference Statement

The marked increase in the use of ultrasound, coupled with concerns regarding its safety and efficacy, prompted three NIH components (the National Institute of Child Health and Human Development [NICHD], the Office of Medical Applications of Research [OMAR], and the Division of Research Resources [DRR]) and the FDA National Center for Devices and Radiological Health to join in sponsoring a consensus development conference to assess the use of diagnostic ultrasound imaging in pregnancy. The conference was held on February 6-8, 1984, after a year of preparation by the panel. After presenting a preliminary report, hearing the testimony of experts, and receiving comments and criticism from the medical/scientific community as well as from the public at large, the panel, consisting of physicians, basic scientists, epidemiologists, nurses, educators, sonographers, and public representatives, considered all the information received and provided answers to the following questions that were posed to the panel.

1. WHAT TYPES OF ULTRASOUND SCANNING ARE CURRENTLY USED IN OBSTETRIC PRACTICE? HOW EXTENSIVE IS THIS USE? WHAT IS KNOWN ABOUT THE DOSE/EXPOSURE TO THE FETUS AND THE MOTHER FROM EACH TYPE?

Estimates of the percentage of pregnant women exposed to at least one ultrasound examination ranged from a low of 15% to a high of 40%. Probably this is a serious underestimate of the true extent of exposure to ultrasound since they do not necessarily include exposure via Doppler devices. Doppler devices, static scanners, real-time equipment of the linear array type and mechanical sector scanners are utilized. The quantity used most often to report instrumentation output is intensity. The time average intensities of the typical obstetrical Doppler devices are within the same range as for pulsed diagnostic equipment.

Dose is a quantitative measure of an agent that is given or imparted and combines quantities such as intensity and exposure time. No dose quantity has been identified for ultrasound. For all practical purposes, fetal dose cannot be quantitated precisely. Thus there are no data on the dose to either the mother or the fetus in the clinical setting. Documentation of dwell time and type of machine is recommended for each examination.

2. FOR WHAT PURPOSES IS ULTRASOUND NOW USED IN PREGNANCY? FOR EACH USE, WHAT IS THE EVIDENCE THAT ULTRASOUND IMPROVES PATIENT MANAGEMENT AND/OR OUTCOME OF PREGNANCY?

Where significant clinical questions exist, the resolution of which would alter the remainder of prenatal care, ultrasound can be of benefit for:

Sponsored by the Mississippi Radiological Society. From the Department of Radiology, University Medical Center, Jackson, MS.

Estimation of gestational age for patients with uncertain clinical dates, or verification of dates for patients who are to undergo scheduled elective repeat cesarean delivery, indicated induction of labor, or other elective termination of pregnancy. Ultrasonographic confirmation of dating permits proper timing of cesarean delivery or labor induction to avoid premature delivery.

Evaluation of fetal growth (eg, when the patient has an identified etiology for uteroplacental insufficiency, such as severe pre-eclampsia, chronic hypertension, chronic renal disease, severe diabetes mellitus, or for other medical complications of pregnancy where fetal malnutrition, ie, IUGR or macrosomia, is suspected). Following fetal growth permits assessment of the impact of a complicating condition on the fetus and guides pregnancy management.

Vaginal bleeding of undetermined etiology in pregnancy. Ultrasound often allows determination of the source of bleeding and status of the fetus.

Determination of fetal presentation when the presenting part cannot be adequately determined in labor or the fetal presentation is variable in late pregnancy. Accurate knowledge of presentation guides management of delivery.

Suspected multiple gestation based upon detection of more than one fetal heartbeat pattern, or fundal height larger than expected for dates, and/or prior use of fertility drugs. Pregnancy management may be altered in multiple gestation.

Adjunct to amninocentesis. Ultrasound permits guidance of the needle to avoid the placenta and fetus, to increase the chance of obtaining amniotic fluid, and to decrease the chance of fetal loss.

Significant uterine size/clinical dates discrepancy. Ultrasound permits accurate dating and detection of such conditions as oligohydramnios and polyhydramnios, as well as multiple gestation, IUGR, and anomalies.

Pelvic mass detected clinically. Ultrasound can detect the location and nature of the mass and aid in diagnosis.

Suspected hydatidiform mole on the basis of clinical signs of hypertension, proteinuria, and/or the presence of ovarian cysts felt on pelvic examination or failure to detect fetal heart tones with a Doppler ultrasound device after 12 weeks. Ultrasound permits accurate diagnosis and differentiation of this neoplasm from fetal death.

Adjunct to cervical cerclage placement. Ultrasound aids in timing and proper placement of the cerclage for patients with incompetent cervix.

Suspected ectopic pregnancy or when pregnancy occurs after tuboplasty or prior ectopic gestation. Ultrasound is a valuable diagnostic aid for this complication.

Adjunct to special procedures, such as fetoscopy, intrauterine transfusion, shunt placement, *in vitro* fertilization, embryo transfer, or chorionic villi sampling. Ultrasound aids instrument guidance that increases safety of these procedures.

Suspected fetal death. Rapid diagnosis enhances optimal management.

Suspected uterine abnormality (e.g., clinically significant leiomyomata, or congenital structural abnormalities, such as bicornuate uterus or uterus didelphys, etc.). Serial surveillance of fetal growth and state enhances fetal outcome.

Intrauterine contraceptive device localization. Ultrasound guidance facilitates removal, reducing chances of IUD-related complications.

Ovarian follicle development surveillance. This facilitates treatment of infertility.

Biophysical evaluation for fetal well-being after 28 weeks of gestation. Assessment of amniotic fluid, fetal tone, body movements, and heart rate patterns assists in the management of high-risk pregnancies.

Observation of intrapartum events (eg, version/extraction of second twin, manual removal of placenta, etc.). These procedures may be done more safely with the visualization provided by ultrasound.

Suspected polyhydramnios or oligohydramnios. Confirmation of the diagnosis is permitted, as well as identification of the cause of the condition in certain pregnancies.

Suspected abruptio placentae. Confirmation of diagnosis and extent assists in clinical management.

Adjunct to external version from breech to vertex presentation. The visualization provided by ultrasound facilitates performance of this procedure.

Estimation of fetal weight and/or presentation in

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotencin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocuranne. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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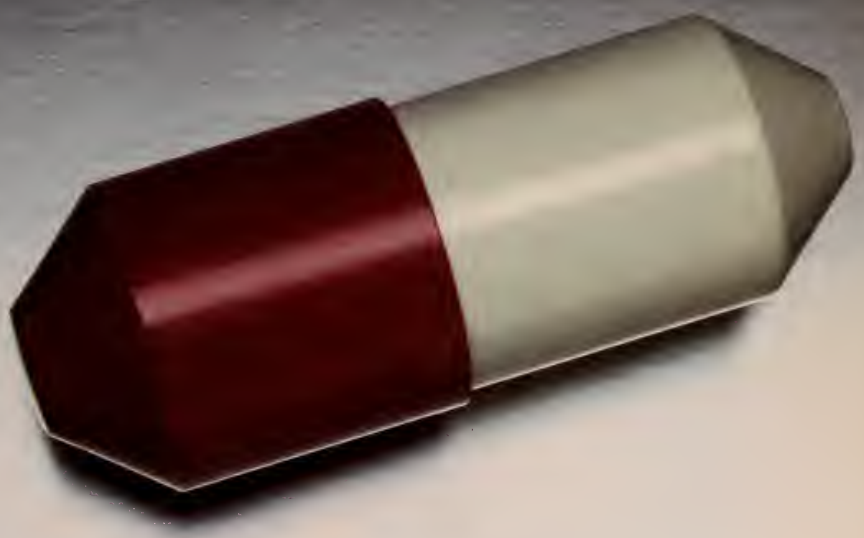
Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



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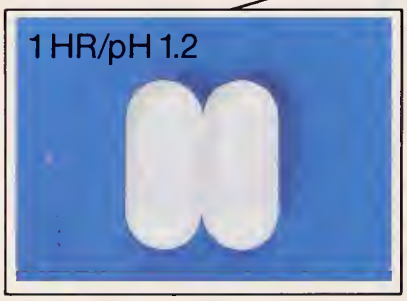

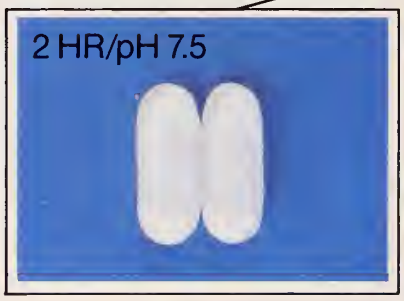

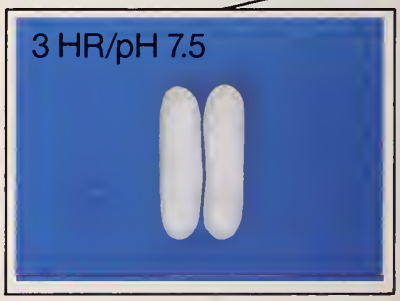

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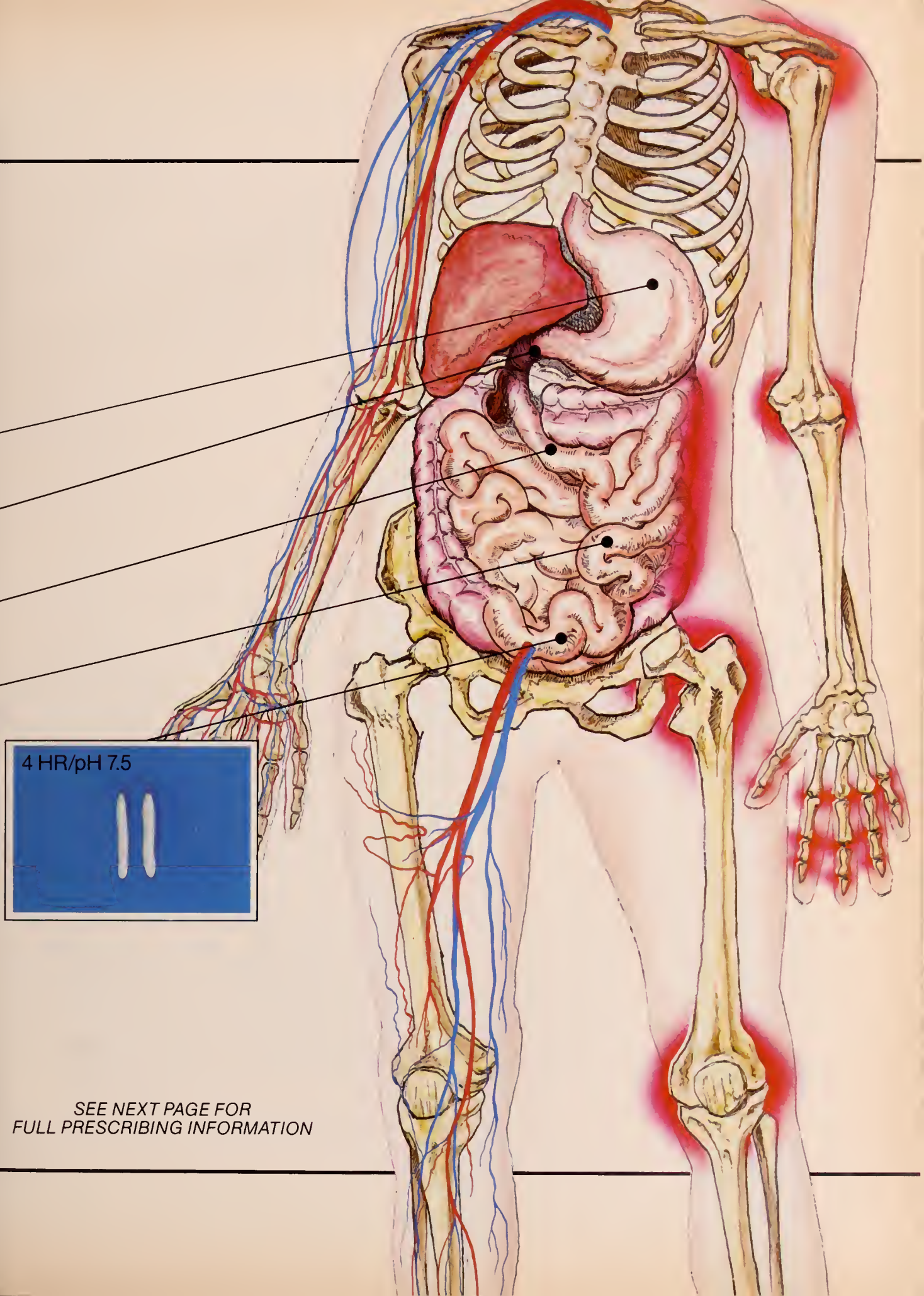

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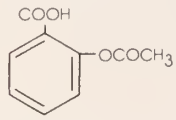
ZORprin (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release, the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions, whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anti-coagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g. slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact. □ Breaking the tablets or disrupting the structure will alter the release profile of the drug. □ It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets — NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**

The structural formula of aspirin is:



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premature rupture of membranes and/or premature labor. Information provided by ultrasound guides management decisions on timing and method of delivery.

Abnormal serum alpha-fetoprotein value for clinical gestational age when drawn. Ultrasound provides an accurate assessment of gestational age for the AFP comparison standard and indicates several conditions (eg, twins, amnencephaly) that may cause elevated AFP values.

Followup observation of identified fetal anomaly. Ultrasound assessment of progression or lack of change assists in clinical decision making.

History of previous congenital anomaly. Detection of recurrence may be permitted, or psychologic benefit to patients may result from reassurance of no recurrence.

Serial evaluation of fetal growth in multiple gestation. Ultrasound permits recognition of discordant growth, guiding patient management and timing of delivery.

Evaluation of fetal condition in late registrants for prenatal care. Accurate knowledge of gestational age assists in pregnancy management decisions for this group.

The panel concludes that diagnostic ultrasound for pregnant women improves patient management and pregnancy outcome when there is an accepted medical indication. Randomized, controlled clinical trials would be the best way in the United States to determine the efficacy of routine screening of all pregnancies.

3. What are the theoretical risks of ultrasound to the fetus and the mother? What evidence exists from animal, tissue culture, and human studies on the actual event of the risk?

A number of epidemiological studies tend to support the safety of diagnostic ultrasound exposure in humans. Some of the more than 35 published animal studies suggest that *in utero* ultrasound exposure can affect prenatal growth. When teratological effects have been found, energies capable of causing significant hyperthermia have usually existed; these levels are beyond the clinical ranges.

A number of biological effects have been observed following ultrasound exposure in various experimental systems, including reduction in immune response, change in sister chromatid exchange frequencies, cell death, change in cell membrane functions, degradation of macromolecules, free radical formation, and reduced cell reproductive potential. It should be noted that (a) some of the studies employed energy levels greater than would be expected to exist in clinical use; (b) *in vitro* exposure conditions to ultrasound used in many of the experiments are hard to place in perspective for risk assessment; (c) some of the observations, for example, sister chromatid exchange frequency changes and induction of chromosomal abnormalities, have not been reproducible.[2] Further study is deserved.

4. Based on the available evidence, what are the appropriate indications for, and the limitations on, use of ultrasound in obstetrics today?

It is the consensus of the panel that ultrasound examination in pregnancy should be performed for a specific medical indication. The data on clinical efficacy and safety do not allow a recommendation for routine screening at this time.

The panel recommends that patients should be informed of the clinical indication for ultrasound, specific benefit, potential risk, and alternatives, if any. In addition, the patient should be supplied with information about the exposure time and intensity, if requested. Patient access to educational materials regarding ultrasound is strongly encouraged. All health care providers who use this modality should demonstrate adequate knowledge of the physical principles of ultrasound, equipment, recordkeeping requirements, indications and safety.

5. What further studies are needed of efficacy and safety of use of ultrasound in pregnancy?

The panel recommends:

1. The study of fundamental mechanisms leading to bioeffects.
2. Laboratory experiments that focus especially on those cellular processes that are most likely to be affected during embryonic and fetal development.
3. Postnatal studies in animals after *in utero* exposure to ultrasound.
4. Exploration of interactions between administered ultrasound and such developmentally significant agents as drugs, nutrition, ionizing radiation, hyperthermia, and hypoxia.
5. Development of improved dosimetry.

A long-term followup of infants involved in a randomized clinical trial would help clarify ques-

tions about the effect of ultrasound on development in humans. Further nonexperimental studies that seek to establish the clinical efficacy of ultrasound should address the question of its contribution to reducing morbidity and mortality. Randomized, controlled clinical trials of routine ultrasound screening in pregnancy should be conducted in the United States. A long-term followup of these infants would help clarify questions about the effect of ultrasound on human development.

Summary

There are no known adverse effects of diagnostic ultrasound on humans despite 25 years of clinical application. However, laboratory studies indicate some phenomena that warrant further investigation. Ultrasound exams should be done only upon clear medical indication. So far, the medical benefits appear to outweigh possible unknown risks. ★★★

500 North State Street (39216)

References

1. The use of diagnostic ultrasound imaging in pregnancy: National institutes of Health Consensus Development Conference Consensus Statement. February 6-8, 1984.
2. Symposium on Sister Chromatid Exchanges and Diagnostic Ultrasound. *Journal of Clinical Ultrasound*, January 1984, 12(1):pp. 3-20.

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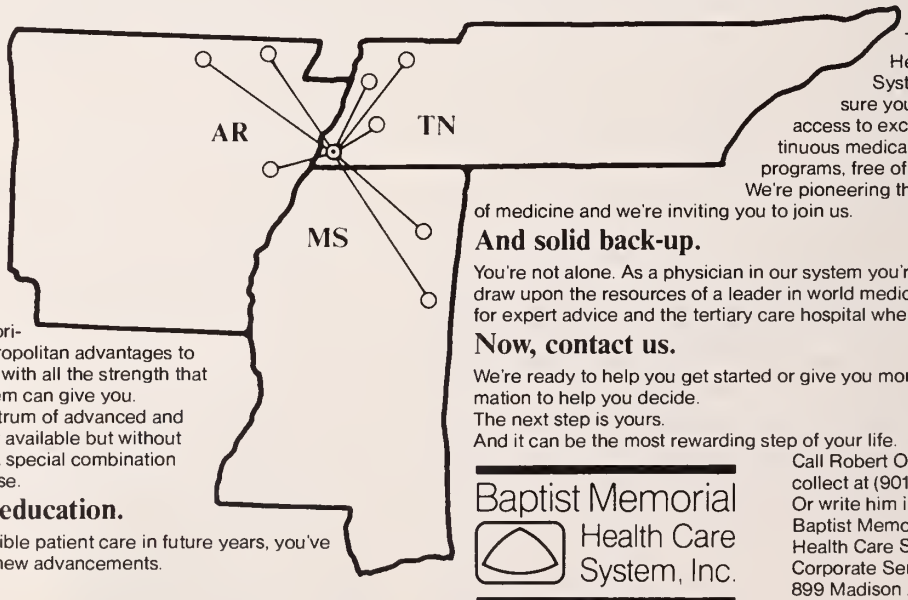

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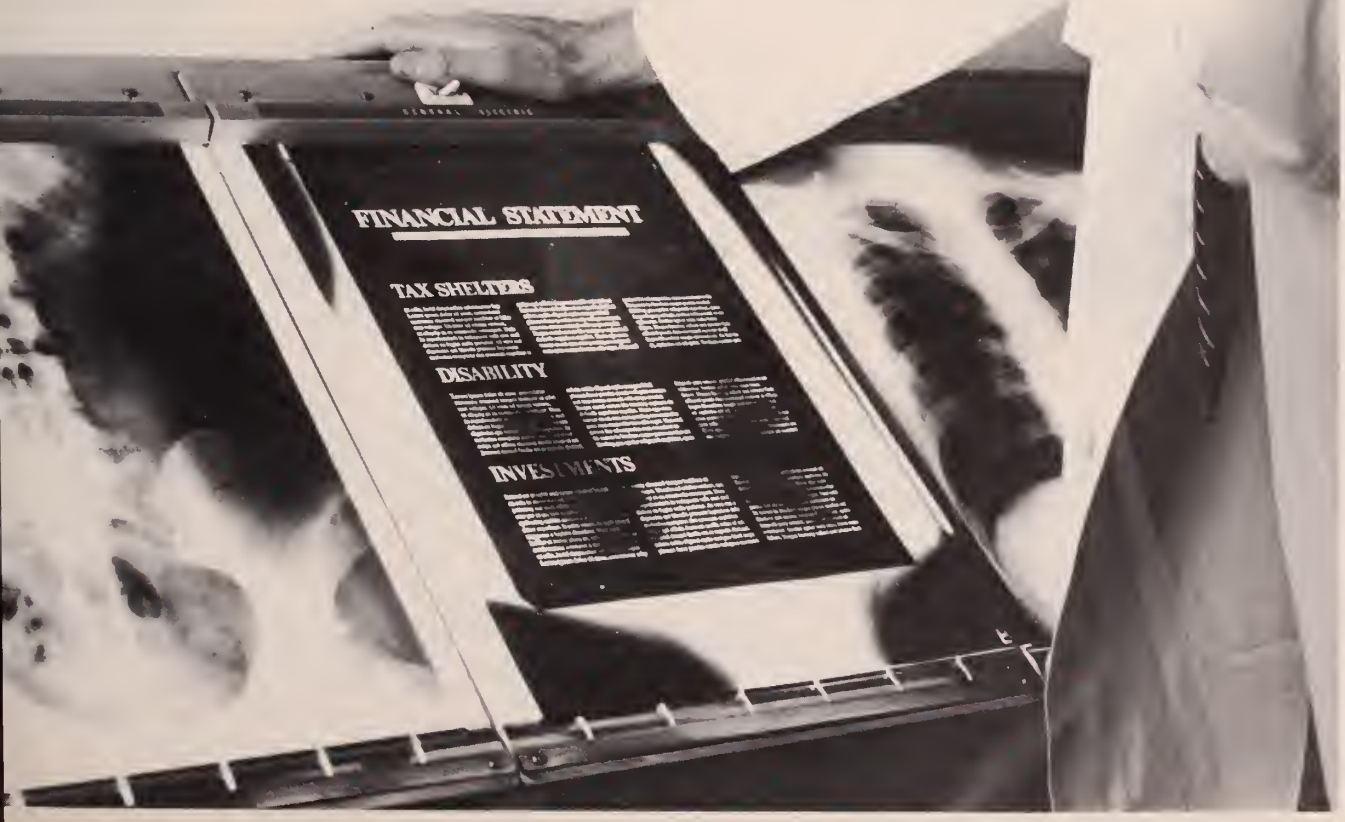

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The UAB Multipurpose Arthritis Center, using a comprehensive team approach, provides therapies for such disorders as: rheumatoid arthritis, systematic lupus erythematosus (SLE), polymyositis, scleroderma, vasculitis, and related connective tissue diseases. As one of the first federally designated Multipurpose Arthritis Centers, it maintains active research into such aspects of rheumatic disease as hereditary factors of susceptibility and connective tissue biochemistry, cellular pathophysiology of rheumatoid arthritis, and the possible role of viruses in the autoimmune diseases.

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- **Reconstructive Joint Surgery**
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- **Physical and Occupational Therapy**
- **Clinical Trials of New Drugs Using Specific Protocols**

The following outpatient specialty clinics are also offered by the Center:

- **Adult Rheumatology: Diagnosis, Treatment and Follow-up**
- **Juvenile Arthritis (JA)**
- **Gold Clinic**

The Multipurpose Arthritis Center is one of 60 departments, divisions, and centers of the University of Alabama Medical Center accessible to you through this toll-free service.

The Center welcomes physician inquiries. To speak with a physician, to consult about a patient or to refer a patient, telephone by using the toll-free MIST number. This service, including the telephone call, is free.

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The President Speaking

"The Ole Ball Game"

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

Baseball season is upon us again, and all of us fans are looking forward to it. The only problem for those of us in the game of patient care is the rules have been changed. This season, we have been placed in a new league where the teams are labor, insurance, Congress, the Administration, bureaucracy with Margaret Heckler of HHS as coach, and a new team — big business. The umpires will be the Federal Trade Commission and the Justice Department.

There are some similarities and some differences in our league and the big baseball leagues. We have our prima donnas and superstars but although we hear a lot about inflated incomes, no one has published any dollar figures to rival that of the baseball players. Their season lasts from April until October, while ours is 24 hours a day twelve months a year. Our ball game is never over, as you know when the phone rings all night long, until the white flag of retirement or the black pennant of death is hoisted. We also don't always get paid by those admitted to our ball park; and frequently those receiving the free passes require the most attention and get the "best seats." Although in baseball the supporters of the losing team go home with long faces, they don't sue the star for dropping the ball; but in our league, any unpleasant outcome may result in a court appearance with one of our players in the defendant's box. Did you ever wonder how much malpractice or "errors and omissions" insurance costs a baseball player?

The DRG's are an example of a governmental squeeze play that will make us feel the pressure when they pull it on us. It will require that we treat a patient as a diagnosis and not as a whole person. For example, if a person is admitted with back pain and spasm, then develops signs of acute cholecystitis while in the hospital, it seems that the patient must be discharged and readmitted for the program to pay for the diagnostic workup and surgery. Also, if we don't have our own agency to collect for physicians, we must collect individually from the hospital.

The Senate team features the Dole hit and run proposal which requires a physician fee freeze but will allow a periodic cost of living increase for those willing to accept assignment for all medicare patients. Coach Rostenkowski of the House team is going for the home run of a stiff fine, loss of hospital privileges, and a year jail sentence for anyone who would not accept mandatory medicare assignment.

Fans, welcome to the new season. It looks like this year and in the future, if we don't get together and act as a team, they are going to make us physicians the ball! ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXV, Number 4

APRIL 1984

Will Freeze Affect Profiles?

A recent letter from the American Medical Association to its membership stated: "We all recognize that payment for physician services is not the major cause of health care inflation. However, we believe the medical community should take a leadership role to control this inflation and that this can be done most effectively through voluntary action."

"As you know, the Board of Trustees and Officers of the American Medical Association have asked that you, along with your colleagues, beginning today, voluntarily freeze your fees for all patients for one year. The Board and Officers also ask that you continue to consider the financial circumstances of each of your patients — especially the unemployed, the uninsured and those under Medicare — and accept reduced fees when warranted."

Following up on that action, the Board of Trustees of the Mississippi State Medical Association voted to support the freeze and asks that the Mississippi physicians voluntarily follow this lead.

Why are physicians alone being asked to voluntarily freeze their fees when it acknowledged in the letter that payment for physician service is not the major cause of health care inflation? The hope that such action will lead to subsequent decrease in the overall cost of medicine and enhance the public image of medicine in this country is rather idealistic.

Generally, physicians are concerned about the need of their patients, whether they be unemployed, uninsured, on Medicare, covered by commercial third party agent, or paying with private funds. Most physicians consider the circumstances presented by each individual patient and are willing to assist when really necessary.

It is difficult, however, to understand why physicians in Mississippi, who are already paid at a lower standard by third party agents than physicians in other areas of the country, particularly by the government programs, are being asked to freeze or reduce fees. An important issue in this matter centers around the computerized profiles obtained by most third party carriers, through which statistics are used to establish a basis for future payments. Are these agents going to utilize frozen or reduced fees offered by Mississippi physicians during this period to calculate our future rates which are already substandard? If we are being asked to follow through with this voluntary action then these agents should volunteer not to enter fees obtained during this period of time into computer profiles on physicians and not use these figures in computing future payments.

MYRON W. LOCKEY, M.D.
Editor

Medico-Legal Brief

"Citizens Beware — Especially Doctors"

A Mississippi Supreme Court majority, in clearing a county weekly newspaper of libel, has created a new concept of determining who is a public figure.

The court majority, in a recent opinion by Justice James Robertson, held that:

(1) Without a "clear falsity of fact" there could be no libel of the doctors in a critical editorial.

(2) People such as the doctors were "vortex or limited purpose public figures" who could not win a libel action unless they showed they were the victims of actual malice.

(3) And such criticism was common in newspaper commentaries nationally with "no one ever dreaming of filing suit."

While all nine justices agreed there had been no libel, only five approved the Robertson opinion.

Three others dissented and said their minority opinion by Justice Francis Bowling should carry the

title "Citizens Beware — Especially Doctors!" They said the majority reasoning could make anyone benefitting from a tax-funded program a target for such words.

The case grew out of an editorial written after trustees of a county hospital, under pressure from three doctors, elected not to renew the contract of the hospital administrator. The doctors, who operated the hospital emergency room for $135,000 a year, had given the trustees what the high court called a "him or us" ultimatum.

The editorial said taxpayers were being raked over the coals with the emergency room operation and that the doctors wanted to get rid of the administrator who was hired to get the hospital out of the red.

The editorial continued, "If I had such a good setup I wouldn't want someone to come along and tear up my little playhouse either."

Bowling, with Justices Armis Hawkins and Dan Lee joining, agreed there had been no libel but said the majority went too far because they affected how a person's good name "may be taken away without recourse."

He said the situation that would result "will be as bad as any that appears in the jurisprudence of this state or any other state."

"If the article is not libelous . . . appellants were not entitled to one thin dime and we should say so without a lot of fancy words . . . ," he said. — *Compiled from news reports.*

AMA President to Address House of Delegates

Frank J. Jirka, Jr., M.D., president of the American Medical Association, will address the opening session of the MSMA House of Delegates on Thursday, May 17, 1984. Dr. Jirka is in the private practice of urology in Berwyn and Barrington, Illinois. He was chosen president-elect of the AMA in 1982 and was installed in his current position in June 1983.

Long active in organized medicine, Doctor Jirka was first elected to the AMA Board of Trustees in 1974. He served as its secretary in 1976-77 and its Vice Chairman from 1977 to 1979. Doctor Jirka has served the Illinois State Medical Society as its President, Chairman of the Board of Trustees, and a Delegate to the AMA House of Delegates. Currently, he is a Councilor of the Chicago Medical Society.

Born July 23, 1922, in Chicago, Doctor Jirka graduated from Knox College in Galesburg, Illinois, before entering the University of Illinois College of Medicine where he received his M.D. degree in 1950. He served his internship and residency at Cook County Hospital, Chicago, from 1950-54. Doctor Jirka is a Diplomate of the American Board of Urology, a Fellow of the American College of Surgeons and the International College of Surgeons.

Motivated by severe injuries sustained as a Navy frogman during World War II, resulting in the amputation of both his legs below the knee, Doctor Jirka has devoted a great deal of his time toward rehabilitation programs. He has served on the President's and the Governor's Committees on Employment of the Handicapped, and has been a Board member of the Illinois Association of Crippled Children as well as the Illinois Rehabilitation Association.

Doctor Jirka is a Clinical Associate Professor in Urology at Loyola University Stritch School of Medicine, a Consultant in Urology at Hines VA Hospital, and was formerly an Associate Professor in Urology at Cook County Graduate School of Medicine. He has been on the Board of Directors of Suburban Cook County Tuberculosis District since 1962 and is currently serving as its President.

116th Annual Session

Mississippi State Medical Association
May 16-20, 1984
Biloxi

On May 16, 1984, the 116th Annual Session of the Mississippi State Medical Association will get underway. The combination scientific/business meeting will be held at the Royal d'Iberville Hotel in Biloxi. Reservations should be made directly with the hotel by completing the reservation cards mailed to MSMA members last month or by calling 388-6610 (Biloxi).

House of Delegates

Sessions of the House of Delegates are scheduled for Thursday, May 17 and Sunday, May 20. Both meetings will begin at 9:00 a.m. Dr. Frank J. Jirka, president of the American Medical Association, will address the opening session. Delegates will also hear an address by Dr. Whitman B. Johnson of Clarksdale, MSMA president. The inauguration of Dr. Ellis M. Moffitt of Jackson as 1984-85 president will take place during the final session.

Delegates will cast ballots for more than 70 nominees who have been selected by the Nominating Committee to fill nearly 30 vacancies in association offices. A list of candidates was mailed to all members 60 days prior to the elections, in accordance with the association's bylaws.

Concurrent Meetings

Among the many medical related groups which have scheduled meetings in conjunction with the annual session are the Mississippi Foundation for Medical Care and the Medical Assurance Company of Mississippi. The Mississippi State Board of Medical Licensure will meet during the week, as will more than a dozen specialty societies and three medical alumni organizations.

Scientific Assembly

Continuing medical education credit will be awarded for the scientific assembly, which begins Friday, May 18. This year's program marks the beginning of a new scientific format approved by the House of Delegates at the 115th Annual Session. Two major scientific sessions will be conducted — a surgery plenary session on Friday and a medicine plenary session on Saturday. Complete programs are described on page 100 of this issue. Highlighting the scientific presentations will be Dr. Phillip Gorden of the National Institutes of Health, who will present the James Grant Thompson Memorial Lecture on Saturday morning.

Special Events

The annual president's reception on Wednesday night will mark the official opening of the five-day session. Television personality Willard Scott will entertain at the annual membership banquet on Friday night. On the concluding night (Saturday) there will be an "Ole Time Political Rally." This poolside party features a Dixieland Band, appearances by Mississippi's Congressional candidates, and addresses by MSMA's two candidates for president-elect.

Sunday morning prayer services have been added to the calendar of events this year. Bring your families and attend either the Protestant services or the Catholic mass. Both services will begin at 8:00 a.m., and a Continental breakfast will be served.

OFFICIAL CALL

To all members of the Mississippi State Medical Association:

The 116th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Wednesday, May 16, 1984, pursuant to Article V of the Constitution. The House of Delegates will be convened at the Royal d'Iberville at 9:00 a.m. on May 17.

The Scientific Assembly will meet during May 18-19, 1984.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

WHITMAN B. JOHNSON, M.D.
President

J. ELMER NIX, M.D.
Secretary-Treasurer

Scientific Program

116th Annual Session

Friday, May 18

MSMA Plenary Session (Surgery)

9:00 a.m. *Surgical Management of Thoracic Trauma*
Watts Webb, M.D., professor and chairman, Department of Surgery, Tulane University Medical Center, New Orleans, LA

9:35 Questions

10:00 *Bladder Cancer*
Howard Radwin, M.D., chairman, Department of Urology, University of Texas Medical School, San Antonio, TX

10:35 Questions

11:00 *Practical Applications of Fine Needle Aspiration Biopsy*
Jill Woodliff, M.D., assistant professor, Department of Pathology, University Medical Center, Jackson, MS

11:10 *In Vitro Fertilization*
Bryan Cowan, M.D., Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS

11:20 *Hip Prosthesis Using Porous High Density Polyethylene Coatings*
James Hughes, M.D., chairman, Department of Orthopedics, University Medical Center, Jackson, MS

11:30 *Head and Neck Reconstruction Using Arterial Based Flaps*
J. George Smith, M.D. and Andy Brown, M.D., Jackson, MS

11:40 *Perioperative Hemodynamic Monitoring and Therapy*
Wilton L. Marsalis, M.D., Meridian, MS

American College of Surgeons, Miss. Chapter

2:00 p.m. *Complications of Coronary Artery Disease* — Dr. Webb

2:30 Questions

3:00 *Medicine and the Marketplace* — Dr. Radwin

3:30 Questions

4:00 *Multiple Use of the Wagner Device in Trauma*
Danny Sparks, M.D., Department of Orthopedics, University Medical Center, Jackson, MS

Saturday, May 19

MSMA Plenary Session — Medicine

8:30 a.m. James Grant Thompson Memorial Lecture
Diabetes Mellitus: What Form Will a Cure Take?
Phillip Gorden, M.D., chief, section on clinical and cellular biology, Diabetes Branch, and clinical director, NIADDKD, National Institutes of Health, Bethesda, MD

9:15 *Esophageal Disease and Non-Cardiac Chest Pain*
Sidney Cohen, M.D., professor of medicine and chief, Gastrointestinal Section, University of Pennsylvania, Philadelphia, PA

10:00 *Environmental Health Problems in Clinical Practice*
Paul J. Wiesner, M.D., director, Chronic Diseases Division, Center for Environmental Health, Centers for Disease Control, Atlanta, GA

10:30 *Transluminal Angioplasty in the Management of Peripheral Vascular Disease*
Francis A. Puyau, M.D., Department of Radiology, Tulane University Medical Center, New Orleans, LA

11:00 *Endoscopic Control of Gastrointestinal Hemorrhage*
James H. Johnston, III, M.D., Jackson, MS

11:15 Questions

MSMA Membership Banquet Features Willard Scott

Willard Scott, weather reporter on NBC's "Today" show, will speak at MSMA's annual membership banquet, Friday, May 18, at the Royal d'Iberville Hotel in Biloxi.

Scott began his career as a page with NBC at the network's Washington, DC station in 1950. At that time he was also a weekend disk jockey for a local radio station. That same year he and a partner formed "The Joy Boys" broadcast team, which entertained the metropolitan Washington area until 1974. Prior to joining the "Today" show, he had been reporting the weather at WRC-TV in Washington since 1967.

During his tenure in Washington, Scott distinguished himself with his public service efforts. In 1979 he was named Washingtonian-of-the-Year by *Washingtonian* magazine. In 1975 he was named Humanitarian-in-Residence by the National Society of Fund-Raisers.

Scott is a 1955 graduate of American University in Washington, DC, with a B.A. degree in philosophy and religion.

Tennis, Golf, Fishing Events On Annual Session Calendar

Registration is underway for MSMA's tennis tournament, golf tournament, and deep sea fishing rodeo. All three events are on the schedule of activities for the 116th Annual Session in Biloxi.

The tennis tournament, sponsored by the Medical Assurance Company of Mississippi, is set for Saturday, May 19, at Hiller Park Courts in Biloxi. Matches will begin at 1:00. Trophies will be awarded in men's and women's doubles competition. Tennis balls and refreshments will be provided.

Golf tournament participants will gather at the Sunkist Course at 11:30 a.m., Friday, May 18. Trophies will be presented for low gross and low net scores. Prizes will be awarded for longest drive, most accurate drive and closest-to-the-pin. Graphic Consultants of Jackson sponsors the annual tournament.

Two of the Gulf Coast's finest charter boats have been reserved for the fishing rodeo, set for Friday and Saturday, May 18 and 19. Boats will leave from the Broadwater Marina at 7:00 a.m. and return at 3:30 p.m. The $65.00 registration fee covers boat rental for the day, soft drinks and sandwiches. Prizes will be awarded for largest catch in Spanish mackerel, bonito and jackfish.

Prayer Breakfast Precedes Sunday House Session

Rev. Whitlock

Sunday morning prayer services will be conducted prior to the House of Delegates session May 20. All members of MSMA and MSMA Auxiliary and their families are invited to attend. A continental breakfast will be served.

Two services are planned, with both scheduled to begin at 8:00 a.m. Protestant services will be held in the LaSalle Room. Catholic services will be in the Dauphine Room.

Rev. Luder G. Whitlock of Clinton, president of Reformed Theological Seminary, will conduct the Protestant services. Rev. Whitlock, who was associate professor at the seminary prior to being named its president in 1978, has served as pastor of Presbyterian churches in Harriman, Tennessee and Hiahleah, Florida.

Father Joe Dilettuso, pastor of Nativity B.V.M. Cathedral in Biloxi, will celebrate mass. A native of Pittsburgh, Pennsylvania, he formerly was pastor of Holy Rosary Church in Hattiesburg and associate pastor of St. Paul's in Vicksburg. He was for three years a teacher at Sacred Heart High School in Biloxi.

116th Annual Session

May 16-20, 1984

Summary of Activities

Wednesday, May 16
MSMA President's Reception

Thursday, May 17
Reference Committee Breakfast
MSMA House of Delegates
Miss. Foundation for Medical Care
Reference Committee Hearings
Medical Alumni Reunions

Friday, May 18
Fishing Rodeo
MSMA Past Presidents Breakfast
MSMA Plenary Session (Surgery)
MSMA Fifty Year Club
Miss. State Board of Medical Licensure
Miss. EENT Association
Miss. Ob-Gyn Society
American College of Surgeons
American College of Emergency Physicians
American College of Pediatrics
Miss. Urology Society
Miss. Society of Plastic and Reconstructive Surgery
Miss. Perinatal Association
Medical Assurance Co. of Miss.
Miss. Emergency Association
MSMA/MSMA Auxiliary Membership Reception and Banquet

Saturday, May 19
Fishing Rodeo
MSMA Plenary Session (Medicine)
Miss. Pathology Association
Miss. Academy of Family Physicians
Miss. Radiology Society
Flying Physicians Association
Miss. Society of Internal Medicine
Miss. Psychiatric Association
Miss. Anesthesiology Society
Tennis Tournament
MSMA Old Time Political Rally

Sunday, May 20
Prayer Breakfast
MSMA House of Delegates

"Ole Time Political Rally" Is Annual Session Party Theme

Registrants at the upcoming 116th Annual Session are invited to join in the fun at a real "Old Time Political Rally." This poolside party will be held Saturday, May 19, from 5:30-7:30 p.m., at the Royal d'Iberville Hotel.

Campaign for your favorite candidates in MSMA's elections, and meet informally with members of Mississippi's Congressional delegation and with current candidates and their wives.

Dr. J. O. Manning of Jackson, chairman of MSMA's Board of Trustees, will emcee this entertaining event, which features refreshments, music of a Dixieland Band, and some special surprises.

Fifty Year Club Will Meet May 18

The MSMA Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century-plus members at a special luncheon on Friday, May 18, at the Royal d'Iberville Hotel.

Members of this special organization include: Drs. S. Lamar Bailey of Kosciusko; T. J. Barkley of Belzoni; Eldon Bolton of Biloxi; Sam B. Caruthers of Grenada; Charles E. Catchings, Jr. of Woodville; Thomas F. Clay of Tutwiler; Stanley Hill of Corinth; Julius L. Levy, Sr., of Clarksdale; Earl L. Laird of Union; Lawrence W. Long of Jackson;

Veronica M. Pennington of Jackson; A. R. Perry of Natchez; Tom Ramsay of Biloxi; Lee R. Reid of Jackson; G. T. Sheffield of Gulfport; Omar Simmons of Newton; William C. Simmons of Bay Springs; Guy T. Vise, Sr. of Meridian; Earl T. White of Greenville; and Homer A. Whittington of Natchez.

Joining the Club this year is new member Dr. G. Swink Hicks of Natchez.

James Grant Thompson Memorial Lecture

Saturday, May 19 **8:30 a.m.**

Diabetes Mellitus: What Form Will a Cure Take?

Phillip Gorden, M.D., Bethesda, MD
National Institutes of Health

Mississippi State Medical Association Auxiliary

Convention Images 1984

Wednesday, May 16

12 noon	Registration, Hospitality
5:30 pm	MSMA President's Reception

Thursday, May 17

9:00 am	Registration, Hospitality, AMA-ERF Boutique
9:00 am	MSMA House of Delegates
10:30 am	Preconvention Board Meeting
2:00 pm	"Personal Home Computers: For Fun or For Real" David Raley, IBM Systems Engineer (Physicians and spouses invited)
3:30 pm	"New Dimensions 1984-85" Billie Brady (Wayne C.) AMA Auxiliary President-Elect
7:00 pm	Ole Miss Alumni

Friday, May 18

8:00 am	Registration
9:00 am	Hospitality, AMA-ERF Boutique
9:00 am	General Session "Images of a Medical Spouse"
12 noon	Luncheon
3:00 pm	Postconvention Board Meeting
6:30 pm	MSMA/MSMA Auxiliary Banquet Willard Scott, Guest Speaker

Saturday, May 19

8:30 am	Past Presidents' Breakfast
10:30 am	"Collecting American Antiques" Joanne Cheek (Howard B.) (Physicians and spouses invited) Door Prize
1:00 pm	Tennis Tournament
5:30 pm	Ole Time Political Rally

Sunday, May 20

8:00 am	Prayer Services
9:00 am	MSMA House of Delegates

PERSONALS

James Achord of UMC was guest speaker for the Baton Rouge Academy of Internal Medicine and also spoke recently at Greenwood Leflore Hospital.

O. J. Andy of UMC presented papers at the recent annual assembly of the Mississippi Academy of Sciences in Biloxi and at a neurosurgical "residents' reunion" at Baptist Memorial Hospital in Memphis.

Bryan Barksdale of Jackson received the Outstanding Volunteer Award presented by the Mississippi Chapter of the Arthritis Foundation.

Bruner Bosio was guest speaker at a course for expectant parents sponsored by the Jackson County Chapter of the American Red Cross.

Henry W. DeWitt of Laurel announces the association of Candace E. Keller in the practice of anesthesiology.

John R. Esters announces the opening of his office for the practice of ophthalmology at 310 Main Street, Suite 101, in Biloxi.

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James Gilmore of Oxford has been recertified by the American Academy of Family Physicians.

W. Mack Gorton of Belzoni has been appointed to the Board of Directors of the University of Mississippi Alumni Association's medical alumni chapter.

David N. Greenhaw announces the opening of his office for the practice of internal medicine at 208 First Street in Booneville.

James Hardy of UMC was inducted into the Royal College of Surgeons in London, England, recently.

David R. Hubbs announces the opening of his office for the practice of obstetrics and gynecology in Brookhaven.

Patrick Hsu announces the opening of his office for the practice of obstetrics and gynecology at 1308 Hospital Street in Greenville.

Alton B. James of Oxford has been elected president of the medical staff at Oxford-Lafayette County Hospital.

Tom Jeffcoat of McComb was inducted as a fellow of the American Academy of Orthopaedic Surgeons in February.

Van Lackey of Jackson was speaker for the annual Youth Press Conference of the American Cancer Society, Mississippi Division.

Doug Lanier of Gulfport was named Outstanding Young Man of the Year by the Gulfport Jaycees.

John Paul Lee of Forest has been appointed to the Board of Directors of the University of Mississippi Alumni Association's medical alumni chapter.

James N. Martin, Jr. of UMC presented grand rounds at Keesler Air Force Base in Biloxi.

Wafford Merrell of Jackson has been appointed to the governing board of St. Dominic-Jackson Memorial Hospital.

T. F. McDonnell of Hazlehurst, 1983 MSMA/Robins Award recipient, was commended in a February 21 resolution adopted by the Mississippi House of Representatives.

Winsor Morrison of UMC was speaker at the recent meeting in Jackson of the Central Mississippi Speech and Hearing Association.

William Nicholas of UMC spoke at a meeting in Columbus of the American Diabetes Association, Mississippi Affiliate, and was guest speaker for the North Mississippi Dietetic Association.

Daksha Patel of UMC presented abstracts at the Southern Society for Pediatric Research meeting in New Orleans.

John M. Purvis of Jackson was inducted as a fellow of the American Academy of Orthopaedic Surgeons in February.

Sandra A. Rhoden announces the opening of her office for the early detection of breast cancer at Woman's Breast Clinic, 1040 North Flowood Drive in Jackson.

Robert R. Smith of UMC was speaker at the Ninth International Joint Conference of Stroke and Cerebral Circulation in Tampa, Florida.

Cliff Seyler of Pascagoula was speaker at a course for expectant parents sponsored by the Jackson County Chapter of the American Red Cross.

Walter R. Shelton of Jackson was inducted as a fellow of the American Academy of Orthopaedic Surgeons.

Maurice E. Snyder announces the opening of his office for the practice of family medicine at 4707 Poplar Springs Drive in Meridian.

Tate Thigpen and Ralph Vance of UMC were program participants for the annual Youth Press Conference of the American Cancer Society, Mississippi Division.

Joseph E. Varner of Hattiesburg has been appointed to the Board of Directors of the University of Mississippi Alumni Association's medical alumni chapter.

Lamar Weems of UMC participated in the American Urological Association's coordinating council meeting in Marco Island, Florida.

"Ole Time Political Rally"

Saturday, May 19
Royal d'Iberville Hotel

There will be fun, entertainment, refreshments, candidates, music of a Dixieland Band, & more! Don't miss it!

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See important information on next page.

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Effective adjunct in short-term treatment of pain

accompanied by tension and/or anxiety in patients with musculoskeletal disorders.

when anxiety magnifies the perception of pain

1-2 tablet dosage 3 or 4 times daily

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(meprobamate with aspirin) © Wyeth

(BRIEF SUMMARY)

DESCRIPTION:
Each tablet contains 200 mg meprobamate and 325 mg aspirin

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds

MEPROBAMATE: Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity

GI: Nausea, vomiting, diarrhea

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur

At levels greater than 20 mg percent, more fatalities than survivals can be expected

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol). Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption

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NEW MEMBERS

Black, William D., Ocean Springs. Born Detroit, MI, Oct. 17, 1936; M.D., Wayne State University College of Human Medicine, East Lansing, MI, 1964; interned Bayfront Medical Center, St. Petersburg, FL, one year; ob-gyn residency, same, 1965-68; elected by Singing River Medical Society.

Chauvin, John Christopher, Aberdeen. Born Ottawa, Canada, Aug. 28, 1946; M.D., Dalhousie University Faculty of Medicine, Halifax, Canada, 1979; one year internship, same; elected by Northeast Mississippi Medical Society.

Coursey, John W., Biloxi. Born Honolulu, Hawaii, Nov. 23, 1925; M.D., University of Maryland School of Medicine, Baltimore, 1959; interned USAF Hospital, Lackland AFB, TX, one year; anesthesiology residency, Wilford Hall USAF Medical Center, Lackland AFB, TX, 1960-63; elected by Coast Counties Medical Society.

Crawford, E. David, Jackson. Born Cincinnati, OH, June 6, 1947; M.D., University of Cincinnati College of Medicine, 1973; interned Good Samaritan Hospital, Cincinnati, one year; urology residency, same, 1974-77; fellowship in urology, University of California Medical Center, Los Angeles, 1977-78; elected by Central Medical Society.

Davis, William A., Jr., Philadelphia. Born Camp Pickett, VA, April 19, 1952; D.O., Kansas City College of Osteopathic Medicine, Kansas City, MO, 1979; interned Richmond Heights General Hospital, Richmond Heights, OH, one year; elected by East Mississippi Medical Society.

Evans, Jack C., Laurel. Born Newton, MS, Aug. 3, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned University of Tennessee Center for Health Sciences, Memphis, one year; family medicine residency University Medical Center, Jackson, MS, 1981-83; elected by South Mississippi Medical Society.

Foster, Jack Byrd, Tupelo. Born Hattiesburg, MS, March 10, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned University Medical Center, Jackson, one year; medicine residency and cardiology fellowship, same, 1979-83; elected by Northeast Mississippi Medical Society.

Guice, Charles E., III, Hattiesburg. Born Memphis, TN, March 7, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Tulane, New Orleans, one year; otolaryngology residency, same, 1980-83; elected by South Mississippi Medical Society.

Lundy, McKinley S., Batesville. Born Montgomery, AL, Oct. 3, 1947; D.O., Kansas City College of Osteopathic Medicine, Kansas City, MO 1979; interned, same, one year; internal medicine residency, University of Tennessee, Chattanooga, 1980-83; elected by North Mississippi Medical Society.

Martin, Hodges L., Philadelphia. Born Slaton, TX, May 6, 1939; M.D., University of Texas Southwestern Medical School, Dallas, 1964; interned Rhode Island Hospital, Providence, one year; internal medicine residency, University of Oklahoma, Oklahoma City, 1968-70; M.P.H., Johns Hopkins University, Baltimore, 1977-80; elected by East Mississippi Medical Society.

Moak, Edward S., Brookhaven. Born Brookhaven, MS, Sept. 25, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned Baptist Hospital, Memphis, TN, one year; internal medicine residency, same, 1981-83; elected by South Central Medical Society.

Mutziger, John C., Philadelphia. Born Natchez, MS, June 23, 1949; M.D., University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1982; interned, same, one year; elected by East Mississippi Medical Society.

Myrick, Andrew J., Jr., Oxford. Born Water Valley, MS, March 21, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Queen's Medical Center, Honolulu, HI, one year; general surgery residency, Ochsner Foundation, New Orleans, 1974-78; elected by North Mississippi Medical Society.

Pearson, Thomas H., Jr., Starkville. Born Clarksdale, MS, Aug. 6, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned, same, one year; ob-gyn residency, same, 1980-83; elected by Prairie Medical Society.

Salter, Victor E., Jackson. Born Hattiesburg, MS, Oct. 27, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned University of Tennessee Clinical Education Center, Chattanooga, one year; interned, medicine residency, and pulmonary fellowship, University Medical Center, Jackson, MS, 1979-83; elected by Central Medical Society.

Savell, V. David, Jr., Meridian. Born Prentiss, MS, Jan. 27, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and pediatric residency, USAF Medical Center, Keesler AFB, MS, 1978-81; adolescent medicine fellowship, Fitzsimmons Army Medical Center, Aurora, CO, 1982-83; elected by East Mississippi Medical Society.

Searcy, Chris J., Columbus. Born Enterprise, AL, Jan. 14, 1953; M.D., University of Alabama School of Medicine, Birmingham, 1979; interned and obgyn residency, same, 1979-83; elected by Prairie Medical Society.

Striegel, William L., Ocean Springs. Born Murphysboro, IL, March 7, 1953; M.D., Tulane University School of Medicine, New Orleans, 1979; interned and internal medicine residency, same, 1979-82; elected by Singing River Medical Society.

Stroble, Charles P., Ocean Springs. Born Pineland, TX, Sept. 7, 1944; M.D., University of Texas, Southwestern Medical School, Dallas, 1970; interned and radiology residency, Wilford Hall Medical Center, 1970-76; elected by Singing River Medical Society.

Supple, Joseph L., Jr., Oxford. Born Shreveport, LA, May 5, 1939; M.D., Louisiana State University School of Medicine, New Orleans, 1968; interned Confederate Memorial Medical Center, Shreveport, one year; ophthalmology residency, LSU Medical Center, Shreveport, 1971-73; elected by North Mississippi Medical Society.

Todd, Michael A., New Albany. Born Memphis, TN, Feb. 27, 1948; M.D., University of Tennessee Center for Health Sciences, Memphis, 1975; interned Baptist Hospital, Memphis, one year; pathology residency, same, 1977-80; elected by Northeast Medical Society.

Yates, Travis W., Lyon. Born Kosciusko, MS, Aug. 21, 1952; D.O., Kansas City College of Osteopathic Medicine, Kansas City, MO, 1979; interned Pontiac Osteopathic Hospital, Pontiac, MI, one year; interned medicine residency, same, 1980-83; elected by Clarksdale and Six Counties Medical Society.

UMC Will Host Internal Medicine Update

An update for physicians in internal medicine is set for May 24 at the University of Mississippi Medical Center.

The program will look at advances in diagnosing and treating adult patients. Topics under discussion include the clinical use of B-blockers and calcium channel blockers, the office management of diabetes, viral hepatitis, hypertension, antibiotic update, preoperative consultation for patients undergoing general surgery, and dizziness and TIAs.

Speakers participating from UMC include Dr. Armin F. Haerer, professor of neurology; Dr. Herbert G. Langford, professor of medicine and director of endocrinology and hypertension, and professor of physiology-biophysics; Dr. Patrick H. Lehan, professor of medicine and director of cardiology; Dr. William W. Long, clinical assistant professor of medicine; Dr. Eric A. McVey III, clinical instructor in medicine; Dr. William C. Nicholas, associate professor of medicine and director of general internal medicine; and Dr. David R. Thomas, assistant professor of medicine.

Course sponsors are the School of Medicine Division of General Medicine, the Department of Family Medicine and the Division of Continuing Health Professional Education at UMC. Dr. Thomas is program coordinator.

Registration fee is $50. The AMA will award 7.25 credit hours in Category I, and the American Academy of Family Physicians 7.25 prescribed hours.

For a brochure and registration information, contact Continuing Education at UMC, 2500 North State Street, Jackson, MS 39216-4505, or call 987-4914.

Next Month in JOURNAL MSMA

The Changing Dynamics of Hospital-Medical Staff Relationships

Current Concepts and Treatment of Pancreatic Cancer (James Grant Thompson Lecture, May 13, 1983)

Discouraging Marijuana Use in Young People

NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

CLASSIFIED

CONSULTING PHYSICIANS. Board eligible orthopedic and psychiatric consultants needed 25-30 hours per week for evaluation of Social Security disability claims. Positions available immediately. For additional information, please call Deborah Warriner, Medical Staff Coordinator, Disability Determination Services, (601) 923-2153.

1984 CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. *Fly roundtrip free on Caribbean, Mexican, & Alaskan Cruises*. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

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PLACEMENT SERVICE

Situations Wanted

NATIVE MISSISSIPPIAN completing pediatric residency in July 1984 seeks location in state. Contact Tom Ireland, M.D., 3516 Casawoods Lane, Clarkston, GA 30021; (404) 296-2940.

BOARD CERTIFIED internal medicine physician seeks location for small rural practice. M.D. from Johns Hopkins University. Contact Edwin B. Struve, M.D., 29 Dellwood Avenue, Chatham, NJ 07928.

ANESTHESIOLOGIST seeks practice location. Box A, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

GENERAL SURGEON seeks relocation in Mississippi. Box S, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

Physicians Wanted

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN. Ideal practice opportunity in thriving central Mississippi community of 5,000. Surrounding trade area has 25,000 population base. Excellent opportunity for OB practice if desired. Situated within one hour's drive of Jackson. Reply to Box B, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

FAMILY PRACTITIONER for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

ESTABLISHED GENERAL PRACTICE for sale or rent. Fully equipped, located at Southland Plaza, Louisville, MS. Contact David Wilson, Jr., P.O. Box 205, Louisville, MS 39339; telephone (601) 773-6052.

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COMMUNITY seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

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Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: **1.** Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD. *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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May 1984

JOURNAL of the MISSISSIPPI State Medical Association

This Month:

James Grant Thompson Memorial Lecture: Current Concepts and Treatment of Pancreatic Cancer

The Changing Dynamics of Hospital — Medical Staff Relationships

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NEWSLETTER

May 1984

Dear Doctor:

The AMA is launching a new program to monitor physicians' experience with the Prospective Payment System (PPS), under which most hospitals participating in Medicare will be reimbursed on a flat rate according to a diagnosis related group (DRG). Physicians are encouraged to describe their experiences in a brief letter and mail to: AMA's DRG Monitoring Project, Department of Health Care Resources, P.O. Box 10947, Chicago, IL 60610.

> While all relevant experiences are of interest, particular areas of concern are: costs of care, quality of care, length of stay, hospital admission/discharge policies, medical staff relations with hospital administration, and utilization review.

In another PPS/DRG related matter, the AMA has objected to the requirement that physicians attest to the validity of diagnoses and procedures performed and to sign a certification form. The requirement was not mandated in the DRG law but was instituted by HCFA's final rule implementing the law. The rule requires that the physician's signature accompany the following statement: "I certify that the identification of the principal and secondary diagnoses and the procedure performed is accurate and complete to the best of my knowledge. (Notice: Intentional misrepresentation, concealment, or falsification of this information may, in the case of a Medicare beneficiary, be punishable by imprisonment, fine, or civil penalty.)"

Mandatory Medicare assignment is dead in this session of Congress. Last month the House overwhelmingly rejected an amendment to the budget reconciliation bill that would have required physicians to accept assignment. The action also eliminated, at least temporarily, a provision that would have legislated a one-year freeze on physician fees.

The FDA last month published a final rule establishing a voluntary program of sodium labeling of food products. The rule requires that the sodium content of foods be included as part of nutrition labeling information whenever such information is provided, whether by requirement or voluntarily. The rule defines the terms "sodium free," "very low sodium," "low sodium," and "reduced sodium" and provides for their proper use in labeling of foods.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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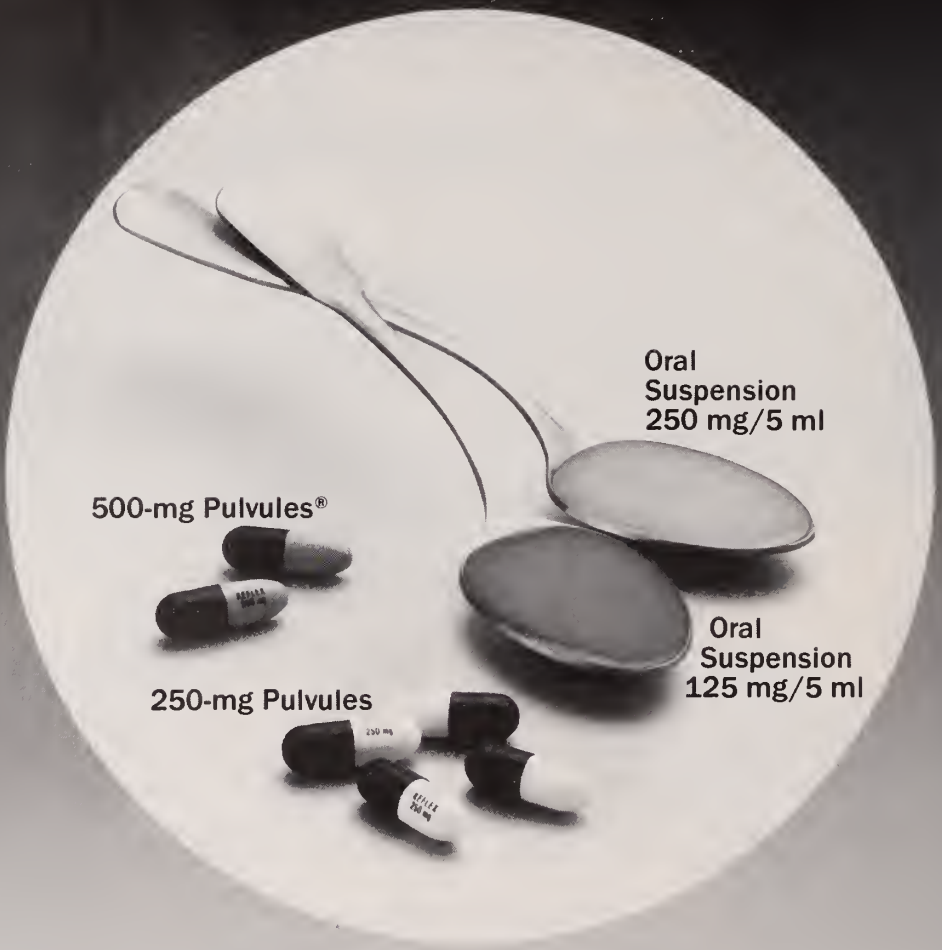

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DATELINE

Most Women Ignore Breast Self-Exam Advice

Washington, DC - Two-thirds (63%) of American women do not perform monthly breast self-examination, despite the fact that 95% report they have heard of the procedure and believe it has value in controlling breast cancer, according to a survey by the Gallup Organization for the American Institute for Cancer Research. Women under 29 and over 50 were almost twice as likely as women 30-49 to have never practiced breast self-examination.

AMA Seeks Representation From Small Hospitals

Chicago, IL - Small hospitals, which are under-represented in the AMA Hospital Medical Staff Section, are encouraged to send members to the third HMSS assembly meeting June 14-18 in Chicago. Although hospitals of 100 or fewer beds comprise almost half of the total hospital population, representation at the first and second assembly meeting was minimal. Each hospital, regardless of size, is allowed to send representatives to the meetings.

MSMA Auxiliaries Receive Awards

Jackson, MS - Two MSMA Auxiliary societies received awards at the annual meeting of Southern Medical Association Auxiliary. For the second year in a row the Jones County/Laurel group won the Feldner Award, which is presented to the county auxiliary submitting the best overall Doctors' Day observance. The Hattiesburg auxiliary received the Guy Smith Kirby Trophy awarded to the local auxiliary submitting the second best overall Doctors' Day observance.

AMA Offers Two New Health Books

Chicago, IL - Two original paperbacks have joined five other titles in the AMA Home Health Library published by Random House. Now available in bookstores are The AMA Straight-Talk, No-Nonsense Guide to Better Sleep and The AMA Straight-Talk, No-Nonsense Guide to Health and Well-Being After Fifty. The library program is designed to bring to the American reader the most reliable, practical and up-to-date advice on health matters.

New Recommendations For HBP Control

Chicago, IL - New recommendations for the detection and treatment of high blood pressure are offered by the National Heart, Lung and Blood Institute in the May Archives of Internal Medicine. The recommendations represent a follow-up to a 1980 NIH report and reflect advances made in detection and treatment since then, including publication of major clinical trial results, introduction of new antihypertensive agents, and analysis of risk data.

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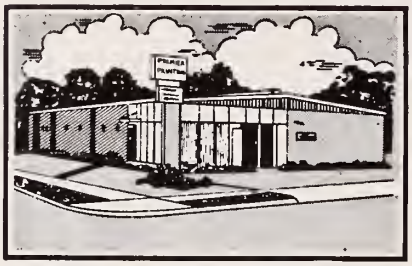

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References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina. PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension. Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina. Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension. Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema. Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Please see PROCARDIA *brief summary on adjoining page.*

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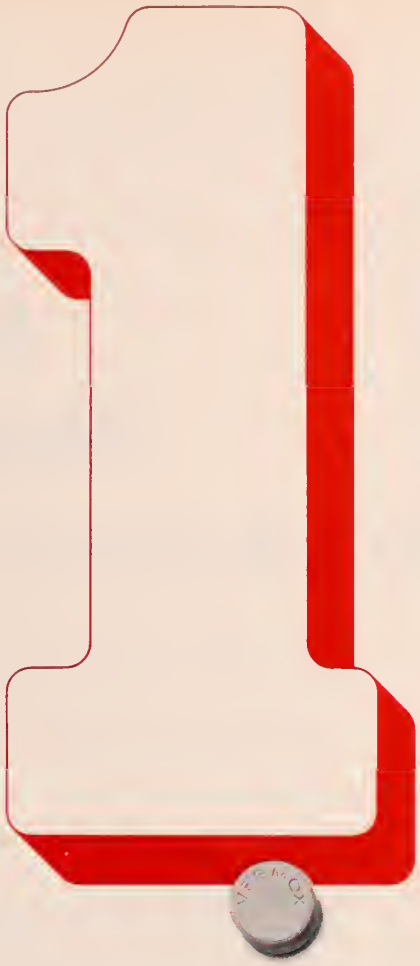

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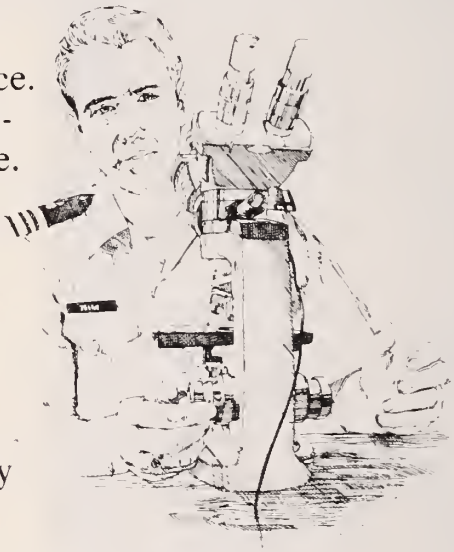

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JOURNAL OF THE MISSISSIPPI MEDICAL ASSOCIATION
May 1984, Volume XXV, Number 5

ORIGINAL PAPERS

James Grant Thompson Memorial Lecture

Current Concepts and Treatment of Pancreatic Cancer

JOHN M. BEAL, M.D.
Chicago, Illinois

The author discusses diagnostic methods and treatment of pancreatic cancer. He observes that the diagnosis is often delayed because the onset is insidious and the symptoms are often vague. He notes that resection remains the best method of treatment, and discusses procedures.

PANCREATIC CANCER has assumed major importance because it occurs frequently and because its incidence is increasing. Cancer of the pancreas ranks fourth among all malignancies as a cause of death and ranks second only to colorectal cancer in frequency among gastrointestinal malignancies. Cancer of the pancreas occurs more often in men than in women and its incidence is greater in blacks than in whites. Pancreatic malignant tumors occur at least twice as frequently in diabetic as in non-diabetic patients; however, diabetes is rarely the first sign of pancreatic cancer. Whether cancer of the pancreas is actually more common in diabetic patients remains uncertain because diabetes in a patient with pancreatic cancer may be related to the cancer itself.

Efforts to identify significant risk factors in the development of pancreatic cancer have been frustrating. The high calorie, high fat, high protein diet of the Western world has been implicated, as has the excessive consumption of coffee. Elderly, heavy smoking, alcoholic men have been proposed as the prototype for the development of this disease.

The diagnosis of carcinoma of the pancreas is often difficult and delayed. The onset is frequently insidious and, initially, may be manifested merely by anorexia and weight loss. The symptoms of carcinoma of the pancreas often are vague and nonspecific.

Clinical Picture

Carcinoma of the pancreas develops in the head of the pancreas in 50%-60% of cases and the majority are not seen by a physician until jaundice appears. Most patients with carcinoma of the head of the pancreas have a prodromal period of vague indigestion, loss of appetite, or nausea, but do not seek medical attention until pain or jaundice develop. Often the patient does not notice the icteric tint of the sclerae or skin which is frequently detected by a friend or relative. Jaundice is typically progressive and unrelenting when it appears.

President, American College of Surgeons (1982-83).

Read before the 115th Annual Session of The Mississippi State Medical Association, May 13, 1983, in Biloxi, MS.

Other symptoms include distension, malaise, back pain, vomiting, and diarrhea. Abdominal pain occurs in at least half of the patients with pancreatic cancer and is usually dull and aching. Mid-epigastric in location, radiation to the back and both lower quadrants is often reported. The patient may obtain relief by sitting or leaning forward. Frequently patients report that the ingestion of food causes an increase in pain; weight loss in such patients is obviously in large part the result of a decrease in food intake.

Carcinoma of the body and tail of the pancreas presents in an even more subtle manner. Jaundice is much less frequent and the vague nature of the pain allows the tumor to grow until a mass becomes palpable or displacement of adjacent organs has occurred. Invasion of the stomach is common in carcinoma of the body of the pancreas. Diagnostic evaluation of these patients using conventional techniques is notoriously unrewarding and the majority are not resectable when discovered.

The ensuing discussion will be devoted to carcinoma of the head of the pancreas. Physical findings are not striking other than jaundice, when present. Hepatomegaly is a frequent finding and occurs more often than jaundice. The gallbladder is palpable in 50%-60% of these patients. Occult blood may be detected in the stool and an occasional patient may have a bloody stool when the tumor invades the duodenum. Abdominal mass and ascites, when present, reflect advanced disease.

Diagnostic Methods

A number of diagnostic tests have been proposed to detect pancreatic cancer. Most are indirect in nature because specific tests which will outline the pancreas, such as radionuclide scans that outline the thyroid, are not available. Radiologic studies of the upper gastrointestinal tract have been employed for many years but are generally informative only in advanced lesions. More recently, a number of methods have been developed which are helpful in the detection of pancreatic disease. These include non-invasive imaging techniques such as ultrasonography and computerized axial tomography (CT scan). In addition, invasive techniques, such as arteriography, endoscopic retrograde cholangiopancreatography (ERCP), duodenal cytologic examination, pancreatic function testing, isotopic scans, and thermography have been tried, with varying degrees of success. For example, the pancreatic scan is a non-specific test and in most centers, including ours, has been abandoned because it yielded a number of false-positive and false-negative results. Arteriography has been disappointing. When successful in detecting a lesion, the findings are generally of vascular displacement and/or vascular encasement, which have been found to be signs of advanced disease.

The assessment of a patient with the clinical picture of obstructive jaundice begins logically with ultrasonography of the biliary system and pancreas. This is an efficient, noninvasive study that can provide pertinent information quickly. It detects cholelithiasis, when present, with a high degree of accuracy, although it is less useful in assessment of dilatation of the bile ducts and of the pancreatic duct. Masses in the head of the pancreas are apparent in many instances by ultrasound examination. Fine-needle aspiration of the pancreas may provide material for cytologic study and is useful in the differentiation of neoplasm and pancreatitis.

Pancreatic function tests, duodenal and ductal cytology, CT scans and ERCP have been rewarding. In patients suspected of harboring pancreatic disease, fluid obtained from the ampulla of Vater may be subjected to cytologic examination. The fluid has a diagnostic sensitivity of approximately 85%. Pancreatic secretory function is abnormal in 60%-90% of patients with pancreatic cancer. ERCP has the advantage that not only can the periampullary portion of the duodenum be visualized, contrast material may be injected into the common bile duct and into the pancreatic duct when the ampulla of Vater is cannulated.

Usually a combination of examinations is required and in the majority of patients, the diagnosis of pancreatic cancer may be established or strongly suspected as the most likely lesion.[1] However, early pancreatic cancer is seldom found. Although a more accurate preoperative diagnosis can be achieved now, the absence of an identifiable high risk group within the population makes it unlikely that the testing of pancreatic function and other discriminatory diagnostic aids in symptomatic patients will provide a means of early diagnosis of pancreatic cancer.

Treatment

Even the most enthusiastic pancreatic surgeon will admit that the results of treatment of pancreatic cancer are discouraging although there has been a marked reduction in the operative mortality since Whipple described pancreaticoduodenectomy in 1935.[2] Biliary bypass alone, however, is associated with an average survival of only approximately six months. In contrast, the average survival after resection ranges from 12-18 months. The only chance for cure rests with resection.

Unfortunately, the majority of patients with carcinoma of the pancreas are not resectable at the time of operation. Our experience has been typical. Seventy-five patients were treated for carcinoma of the head of the pancreas at the Northwestern Memorial Hospital between January 1, 1976 and December 1980. Only 6 (8%) were suitable for resection, which emphasizes the generally poor prognosis for this disease.

The recurring question with biliary bypass is whether a gastrojejunostomy should be performed at the same time. Longmire and Traverso[3] reported that the subsequent addition of gastrojejunostomy to biliary bypass prolonged the average survival. In contrast, in those patients who had biliary bypass and gastric decompression performed at the same time, average survival was significantly decreased. Walter Lawrence and his associates,[4] however, concluded that prophylactic gastrojejunostomy should be performed in most patients with unresectable periampullary carcinoma presenting with biliary obstructions.

Our experience is similar to that reported by Longmire and Traverso.[3] Eight patients had both biliary bypass and gastric decompression performed at the same time and had an average survival of 7.1 months. Thirty-nine patients who had only a biliary bypass survived for an average of 8.6 months. The 10 patients who initially had a biliary bypass and, at a later date had a gastric bypass, had an average survival of 10.2 months.

A significant question arises whether a tissue diagnosis is required in certain patients before pancreaticoduodenectomy is performed. In most patients biopsy of peripancreatic lymph nodes, bile duct and/or pancreatic cytology, ampullary or duodenal wall biopsy or transduodenal needle biopsy will provide histologic evidence of neoplasm sufficient to warrant resection. In some patients these measures are unsuccessful and the decision to perform a definite operation must be based on gross pathologic assessment. A mass in the head of the pancreas in a patient 50 years of age or older with progressive jaundice and without an alcoholic history is almost certainly a neoplasm, if common stone has not been found by other tests. Most surgeons recommend resection in such patients.[5] Patients with small carcinomas and without capsular or lymph node invasion have a much better survival rate. It is in this group of patients that it is most difficult to obtain a tissue diagnosis. Emphasis should be placed on the need for a careful and organized approach to obtain a tissue diagnosis before undertaking a formidable operation, such as pancreaticoduodenectomy. If the steps outlined are followed, a tissue diagnosis should be made in more than 90% of patients.

The extent of resection has been a matter of debate in recent years. The low survival rate after pancreaticoduodenectomy has encouraged surgeons to attempt resections that are more extensive. Total pancreatectomy and regional pancreatectomy have been proposed in an attempt to include greater lymphatic drainage and to encompass possible extension of the tumor. Carcinoma of the pancreas has been discovered to be multifocal in some patients and thus has supported the concept of total pancreatectomy. Another argument that favors the use of total pancreatectomy is that it eliminates one hazardous suture line, the pancreaticojejunostomy, notorious for leaking.

The issue of the extent of resection for carcinoma of the pancreas has not been resolved. Regional pancreatectomy is seldom, if ever, indicated. It has carried a high morbidity and mortality without demonstrable benefit as far as palliation or cure. Total pancreatectomy is a more extensive procedure than pancreatoduodenectomy. Diabetes occurs in all patients after total pancreatectomy and, in addition, problems with fat metabolism are accentuated. The incidence of multifocal disease has not been clearly established and recurrence in the remaining pancreas can be reduced by obtaining frozen sections at the margins to detect residual or multicentric disease. In several series, the operative mortality for total pancreatectomy is approximately three times that reported for the standard Whipple procedure. In addition to a significant postoperative complication rate, there have been a number of later deaths from the diabetic complications.[6, 7] At this time, there is a lack of convincing data that the survival rate and quality of life is improved with total pancreatectomy. This debate, however, is far from closed. In our own series, the only long term survivor (56 months without evidence of recurrence) is a patient treated by total pancreatectomy.

Longmire and Traverso[3] have recommended that total pancreatectomy should be reserved for those patients with demonstrated multicentric disease and for those in whom the remaining pancreas is not suitable for a technically satisfactory anastomosis. They have emphasized the importance of frozen section examination of the margin of the transected pancreas at the time of pancreaticoduodenectomy and advise total pancreatectomy if residual neoplasm is detected. They also noted the increased risk of pancreatic fistula in patients when the pancreatic duct was small in caliber and the pancreas itself was

friable and soft. In their opinion, total pancreatectomy was indicated under these circumstances.

Summary

In summary, the diagnosis of carcinoma of the pancreas is often delayed because the onset is insidious, the symptoms are often vague and the diagnosis is seldom made in the early stages of the disease. Resection remains the best method of treatment. Pancreaticoduodenectomy is recommended when the carcinoma is confined to the head of the pancreas and lymph node metastases have not been demonstrated. Total pancreatectomy is advised for demonstrated multifocal disease or when pancreaticojejunostomy is technically difficult. ★★★

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SPECIAL ARTICLE

The Changing Dynamics of Hospital-Medical Staff Relationships

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It is a privilege and an honor to be here to participate in your association's proceedings.

First, I bring you greetings from the AMA's new Hospital Medical Staff Section (HMSS). The birth of HMSS in Chicago last June was an exciting and fulfilling event, probably more fun than its conception in the House of Delegates some months previously. And that is unusual for most conceptions! We are now well along in infancy and acquiring a personality of our own.

This organization was created by AMA to address and discuss in one forum the growing needs of physicians and hospital medical staffs to deal with a variety of issues, including the new economics and new contracting relationships developing in medicine: HMOs, PPOs, IPAs, joint ventures and DRGs. It was formed to look at and work out our relationship with hospital administrators, hospital boards, health care corporations and multiple institutional systems in this new world of rapid change in the economics of medicine.

These are extraordinarily difficult times for health care in the United States, as federal and state as well as local governments, business leaders, insurance companies and regulatory agencies focus on dollars spent for health care and exert every effort to shrink the system. I would like to provide a brief historical overview of where we have been, where we are and a glimmer of where we are heading in medical care delivery in the United States and, in so doing, offer up some of the challenges and issues for hospital medical staff and physicians everywhere.

"There is an old Chinese proverb that says 'if we don't change our direction, we're going to end up where we're heading.' We physicians are at a crossroad now, and the time has come to take a look at our direction."

Physicians Are at a Crossroad

There is an old Chinese proverb that says "If we don't change our direction, we're going to end up where we're heading!" We physicians are at a crossroad now, and the time has come to take a look at our direction. Let's begin with where we are now.

Hospitals, indeed, are now firmly feeling the squeeze, with changes in all states from cost reimbursement to prospective reimbursement and with caps on inflation, new programs, equipment and expansion in existing services. The DRG approach as applied to Medicare is upon us and will surely be expanded to all third party payers, and probably to physician payment, as well as hospital payment. Case management and risk management are the buzz words, and while the hospitals have been the initial target, because the lion's share of dollars are spent there, it is clear that little can be accomplished in cost containment without substantial physician involvement in the process. The TEFRA Act of 1982, which limits payment for certain kinds of services performed by in-hospital physicians, once again uses the hospital as the vehicle for conformance but clearly targets physician reimbursement as a cost control measure.

Presented at MSMA's Health Issues Seminar, March 3, 1984, Jackson, MS. Dr. Peebles is chairman of the governing council, AMA Hospital Medical Staff Section. He is associate clinical professor of pediatrics at Harvard Medical School and director of education, Children's Service, Massachusetts General Hospital.

It should be realized by all of us that prospective payment systems, or pre-payment systems, determine who is in charge of the system! Fee-for-service and cost reimbursement kept physicians in charge. Tinker with payments in any significant way, and you change the system. The new prospective payment mechanisms tend to put the hospitals in charge, because they have been given the control, even though they can't do the job without *physicians'* active support. Pre-payment, as in HMOs, gives control to whoever is running the pre-payment plan, as opposed to usual and customary fee-for-service which allowed physicians to operate independently, essentially as small businessmen, and retain control over their own activities, over individualized care for patients, and, even more significantly, over the quality of that care.

Physicians may not feel the total impact of the changes mandated by these laws for three to five years, yet the structural changes are going on and will continue to be in place. It is vital that the debate on appropriate approaches to cost control in health care be broadened to include physicians and the general public, so that we all have the opportunity to carefully examine the consequences, shape the laws in a workable fashion, and buy into them before they are thrust upon us.

Patients have yet to be brought into the play, but the federal initiatives toward tax reform in placing a cap on tax preference treatment for health care benefits, as well as pressure from the federal government in entitlement programs and from individual industries across the nation to shift first dollar coverage to consumers of medical care and expand co-payments and deductibles in the hope of developing a fiscally responsible consumer with real out-of-the-pocket-book responsibility are already developing. Part of the responsibility for the knee-jerk passage of these changes in laws and regulations lies with physicians for not getting involved actively and collectively to initiate new approaches to problems as they arise.

American medicine is driven by science and technology, and the authority of physicians in our modern society derives increasingly from their competence in utilizing this science and technology wisely for the benefit of patients. We are, indeed, at a crossroad, and the direction we choose is going to determine whether physicians will dominate, or even substantially influence, the organization of the scientific and technologic bureaucracy which has become so costly that it makes up 10.5% of the gross national product in the United States (450 billion dollars) or whether physicians will merely become employees of vast multi-institutional bureaucracies dominated by big business. Government, by an odd combination of regulation, pro-competitive policy and dramatic restriction of funding, is mandating a cost shift to employers and employees. Hospitals are taking it on the chin. Physicians, as well, are being asked to absorb a share of the cost shift. Government will undoubtedly retain some sort of a safety net for the poor, but, increasingly, Reagan policies are totally reversing the paternalistic trends of the Great Society legislation of the 60s. Through inadequate funding of federal and state entitlement programs and through cost shifting by industry, second and third class medical care systems are developing.

". . . the direction we choose is going to determine whether physicians will dominate, or even substantially influence, the organization of the scientific and technologic bureaucracy which has become so costly that it makes up 10.5% of the gross national product . . . or whether physicians will merely become employees of vast multi-institutional bureaucracies dominated by big business."

There is now a voluntary freeze on physicians' fees across the country. This will be mandated also on Medicare fees. Legislative pressure will build to push physicians to accept assignment in entitlement programs at both federal and state levels. If these initiatives are successful, then, because of the new symmetry in the health care system, all third party payors will seek the same treatment and mandatory fee schedules will be increasingly imposed on physicians. Fees will be reduced, probably inappropriately.

Physician authority in our society was never higher than in the past decade. Perhaps it has peaked, as we have passed into the new "knock the Doc" era of increasing malpractice suits, wanton charges of fraudulent abuse against physicians and just plain bad publicity. While physicians individually continue to enjoy the admiration and respect of their own patients, as a professional group, physicians do not today have that same support. They are coming under closer scrutiny, and, certainly, the media does not hesitate to target physicians and to headline the negatives whenever the opportunities arise. It seems to sell papers and keep Nielson ratings high!

The hospital medical staff has been likened to a dragon sleeping in the hospital lobby. Most administrators understand what happens when you kick that slumbering dragon. The dragon rears up, thrashes

his tail, snaps his jaws and breathes fire all over the place. Somebody's likely to get hurt before the dragon slides back into his customary somnolent mode. Administrators know this and are, therefore, likely to leave the dragon alone. But we physicians must now wake up that sleeping dragon, and run the risk of a little heat and even maybe fire in order to stimulate some action, and, hopefully, act together. Because individual physicians practicing as small business entities are not well organized and have little collective clout, we must begin to give up some of this cherished independence to join together in larger groups, whether they be professional organizations, hospital medical staffs, group practices, pre-payment foundations or practices, PPOs, joint ventures, or whatever else we can initiate; we must join together for strength and take the leadership in order not to become simply employees of vast health care corporations.

Transformation of American Medicine

Well where have we been? How did we get here? Have physicians always had it all their own way? Not by a long shot! Take a look at Paul Starr's account of the past in *The Social Transformation of American Medicine* — a source book that should be on every physician's reading list, as indicated by the following comments derived from his work.

The rapid growth of hospitals began toward the end of the 19th century. In 1871 one survey reported fewer than 200 hospitals while by 1920 there were more than 6000. Today there are 6999 acute care hospitals in the country. This dramatic growth in hospitals accompanied the industrial revolution, the coming of the railroads and other improved means of transportation in the development of larger population centers. At this time also the beginning rapid expansion of medical knowledge, providing a scientific basis for medical care, set the stage for more specialized medical procedures carried out by specialists working in bigger and better equipped hospitals. As the reliability and credibility of physicians and hospital care grew and the care became more procedure-oriented, so professional fees became more justified in the minds both of physicians and their patients and, as well, became more oriented along the lines of a specific fee for a specific procedure. The growing demand by patients for more hospital care, particularly more procedurally oriented surgical hospital care, increased the financial needs of hospitals to provide the equipment and facilities and, ultimately, the expanding technology that these procedures required. The hospital administration recognized that the need for dollars had very much outgrown the philanthropic capability of the trustees to meet these financial needs, and, rapidly, hospitals became much more dependent on the activities of physicians within hospitals for their financial stability. The medical care system became an expanding market and physicians' input was vital to the hospital's security. Picture, also, that this was the time of the Flexner Report, the closing of the diploma-mill medical schools, increasingly tough requirements for entrance into medical schools and a carefully controlled and well orchestrated decrease in the number of physicians entering practice. It rapidly became a seller's market, and the physician's autonomy and authority were established.

> ***"The hospital medical staff has been likened to a dragon sleeping in the hospital lobby . . . we physicians must now wake up that sleeping dragon, and run the risk of a little heat and even maybe fire in order to stimulate some action, and, hopefully, act together."***

Contrast that with what is going on today. After a decade of federal policy directed at flooding the market, we anticipate there will be 40% more physicians entering practice by 1990. It is also estimated that there are already more than currently needed, though distribution is not optimal. Competition between physicians is a reality once again. Hospital beds, rather than undergoing the rapid expansion of the early decades of this century, are now being targeted for shrinkage. Rather than cost reimbursement, prospective reimbursement with predetermined caps is the order of the day. Despite constant scientific breakthroughs and expanding technology, every effort is being made to constrict the medical care delivery system by the allocation of fewer and fewer dollars relative to inflation. Hospital beds will close or convert; hospitals will close; physicians will feel the squeeze.

Let us remember, also, that the application of science in medicine only began to impact patient care about 50 years ago. In Lewis Thomas' recent book *The Youngest Science*, he dramatically recalled the three useful drugs available to his father, who practiced in the 1920s. They were morphine, digitalis, and the newly-discovered insulin. Adrenalin was available but found relatively little use. Here, today, we have a renal dialysis program caring for tens of thousands of people at a cost now exceeding two billion dollars annually; we have organ transplant no longer experimental, but available only at high cost.

We have a fantastic armamentarium of drugs! And now the new technology explosion! We have lasers and nuclear magnetic reactors, fabulous new scanning techniques — and most come with a huge price tag. Is it any wonder that the cost of medical care has accelerated as rapidly as it has? Yes, the cost is high, but after all, there is a price tag for every purchase in every field.

"A fundamental issue . . . is whether an expansion in societal dollars devoted to medical care amounting to 0.3 percent of the gross national product a year is too high a price to pay for such great advances at this time. . . ."

A fundamental issue we physicians need to address is whether an expansion in societal dollars devoted to medical care amounting to 0.3 percent of the gross national product a year is too high a price to pay for such great advances at this time. Though the percentage is small, it does represent huge multi-mega-bucks, and certainly, in a world of finite resources, there have to be cost control and substantial savings wherever possible in order to make certain that the maximum number of advances are available to the maximum number of people. Despite the tax revolt, proposition 2½, and all of the other people-inspired, grass root rollbacks in tax spending brought on largely by a depressed economy, the people have not yet spoken on health care costs. It is entirely possible that, given an appropriate presentation of the facts and opportunities, the people will not wish to cut the heart out of medical progress!

Nevertheless, the relative merit of these huge medical and social expenditures must assume more importance for physicians. Consider, for example, that the HHS budget proposed for 1985 is *318* billion dollars, a sum exceeded only by the total budgets of the United States and USSR ($600,000/minute; $36.3 million/hour). Of this, 96% goes to entitlement programs — with two thirds of that for those over 65, who make up only 12% of our population. We also added 700,000 elderly to the rolls last year. As you can see discretionary programs get crowded out.

I recently had the opportunity to sit in on the annual departmental report of NCI to its advisory board. We spend *one* billion dollars on the NCI budget annually. That's a lot of money! Yet Dr. Vince DeVita runs a very businesslike department. We get a lot for our money! Yet in one year the defense department spent *eight* billion dollars in cost overruns — we received nothing for those dollars — that's simply bad management! Consider the cancer mortality figures — most are very much lowered since the war on cancer was declared in 1973. Yet look at lung cancer figures. In the 10 years ending 1980, relative mortality has increased in white males about 47%, while in white females it has increased 90%. Rates in blacks are even higher! And yet we continue to have hundreds of thousands of people in this country today making billions of dollars a year rolling and selling cigarettes, while congress continues to vote subsidies to tobacco farmers!

The emphasis for medical institutions is now on unbundling to develop different legal entities which can escape the caps imposed by law and by various regulatory agencies, as well as to enter new and more profitable markets; mergers to enhance total profitability and to encourage shared services especially in administration and technology and the formation of multi institutional systems. Physicians, who can learn anything, even the business of medicine, must come out of their lethargy. That sleeping dragon in the lobby must wake up, breathe a little fire around if necessary and then constructively insist upon a firm, responsible and accountable place in the new organization of medical care systems. Physicians may be, but do not have to be, chief executive officers of hospitals and other health care institutions. Physicians may be and should be on boards of trustees, not just representing the medical staff, but, more broadly, representing a medical view of the interests of the community-at-large in the local medical care system. Physicians may and probably should seek posts as paid chiefs of service responsible for their own budgets, or, depending on local circumstances, positions as directors of medical affairs, vice presidents of medical affairs, with enough longevity in office and enough salaried time to initiate firm medical leadership, shaping the changes that are taking place. The responsible management of our health care system may become a requirement for practice today. Physicians, individually, have always accepted some responsibility for the medical economic welfare of their individual patients. Now we must actively seek to share this responsibility for our local community and for the system as a whole.

Optimal medical care delivery is a partnership; a partnership in which the physician provider of care is actually an advisor, but also a careful and astute manager of resources, writing orders encompassing 80% of the cost of care. The patient is the user of available resources; he is a major key to cost control success as he, alone, decides and directs his life-

"Physicians can truly take some positive steps to develop innovative approaches which will both enhance the image of the physician . . . and develop the appropriate incentives that will see the cost containment responsibilities are maintained."

style, which accounts for 75% of the risk factors in health. Finally the payors of care — industry and the government — must be actively involved in the partnership. Creative and dynamic tension will exist between the partners, and we must get used to it. Also, there must be incentives for all partners in this management game.

Positive Steps to Take

Now for some good news! And high time! There are directions we can take!

Physicians can truly take some positive steps to develop innovative approaches which will both enhance the image of the physician as a responsible health care provider and develop the appropriate incentives that will see that cost containment responsibilities are maintained.

The concept of the Hospital Medical Staff Section, as a forum for sharing the many aspects of the relationships of practicing physicians with their hospitals, has arrived in timely fashion. The appropriate locus for initiation of discussion is in the hospital medical staff organization itself, in the hospital. And the logical extension of discussions is in a process that proceeds from hospital staff to county or district societies to state societies and on to the national level in organizations of hospital medical staff sections. This representation from each hospital in local and state society sections linked to a national section has the potential for tremendous new impact! Information and resources will be generated and move both ways with the power both of real grass roots representation and state and national clout in dealing with issues effectively. If the Government Council of the HMSS had only one message to bring to you today, it would be to organize those local and state medical staff sections in reasonable symmetry with the AMA Section so that the representation and networking of ideas interlock to provide the strengths and power that are going to be necessary to meet the problems that lie ahead.

As Plato said, "The punishment of wise men who refuse to take part in the affairs of government is to live under the government of unwise men." We must participate!

During this session we might wish to evaluate and discuss together some of the following issues and approaches, all of which require physician initiative, physician understanding, active physician involvement, and a willingness to give up a little bit in order to join together for more effective action:

(1) *Consider revision of Fee-for-Service.* Somehow we must let the public know that physicians will provide, on their own initiative, reduced fees for care for at least a limited number of our less fortunate citizens who may be financially up against it, out of a job, or in other difficult circumstances. And generally, physicians are willing voluntarily to provide such service, while at the same time they are understandingly less willing to join a system that requires that they accept payment for services at less than cost. The AMA has followed Massachusetts, Texas and California in making this statement. Each state should express the principles expressed by the AMA.

Though some feel that fee for service practice will not be the predominant mode of contractual health care delivery by the end of the decade, a revision of present fee-for-service schedules seems imperative. Legislative initiative must be sought on a state-by-state basis to develop immunity from anti-trust action in order to allow interspecialty societies to negotiate revised fee schedules. Since negotiated fee schedules have usually been procedure-oriented and arranged by insurers' negotiations with the individual specialists, it is high time that interspecialty societies, sitting together, looked together at the fees charged for procedures, recognizing there is only one reimbursement pot for all, and that there are no more dollars. There is little doubt that cognitive endeavors in medicine have been relatively undervalued in fee schedules, while technical skills in a procedure have been over-emphasized. If an individual physician receives $1500 for a 15 minute procedure, he had better plan to be the only individual in the county able to do that procedure in order to capture such a fee. If he is so much better than anyone else in that procedure and can command a continuing volume, then let him individually charge a standard, more modest fixed sum which insurance carriers will pay and then balance bill for the rest. But that balance billing sum should not be fixed by a fee schedule.

The freedom to balance bill may at times seem to the public a license to fee-gouge by physicians, but at least it puts the onus on the patient to look up front at the total fee involved over and above the fee schedule and to choose a particular physician for the procedure. Specifically, physicians might get

together, under immunity from anti-trust laws, negotiate a floor for fees which will provide adequate reimbursement for all third party agencies, and then balance bill for the rest, incorporating incentives for cost saving by site of provision of care, i.e., out-patient surgery or office surgery should be enhanced by the fee structure.

(2) *We Must Understand PPOs.* PPOs are new and extremely variable in structure and benefits. They usually involve a standard indemnity health insurance payment plan with deductibles and co-payments set at certain levels and then, either improved benefits by waiver of these deductions and co-payments if a patient chooses care from a preferred provider, or some sort of discounted care for either the co-payments or deductibles or in the fee-for-service charges if a patient chooses the preferred provider.

The PPO tends to perpetuate the fee-for-service approach, but involves utilization review of case management for individuals over the long haul. PPOs may be initiated by hospitals, by physicians or groups of physicians, by insurance companies or by industry. Once again it behooves physicians to be very much involved in their development, organization, and management if they want to participate at all in these organizations, in order that medicine has appropriate input to the fundamentals of patient care. Of themselves, PPOs do not usually offer significant positive incentives to physicians, but rather discounts and disincentives. PPOs offer no more to hospitals. They do not offer much in the way of incentives for patients to keep costs down once the choice of provider has been made. And, finally, they offer industry and/or the controlling authority most of the benefits of whatever savings are experienced.

(3) *We must look at HMOs.* HMOs offer specific incentives, particularly those organized around group practices, for risk management of hospital and ambulatory patients. With risk pools set up, relating to cost per day and number of days per thousand, incentives are constantly present to exert cost control. This approach must be accompanied by excellent utilization review and quality control in order to ensure the maintenance of high quality. Though there is no magic in these three letters, if you choose to join an HMO, make sure that physicians are involved in its management or administration!

(4) *We must actively deal with DRGs.* DRGs are the talk of the day — another three letter acronym and here to stay, at least for a while, encompassing both hospitals and physicians. It is up to us to develop alternative approaches of case management and an organization that involves physicians joining together. Get involved with DRGs, and understand them, and exert influence to appropriately improve their application to cost control, or develop the data to discard them.

(5) *Establish Multi-institutional Partnerships.* Paul Ellwood, of Interstudy, has developed and set forth a joint venture concept he calls MeSH, a new four letter acronym so specifically designed at the request of his granting agency, the Hartford Foundation, who told him that if he invented anymore three letter acronyms such as HMO, PPO, IPA, DRG, they wouldn't fund him anymore. MeSH was his answer, really a joint venture, involving multi-institutional partnerships. The concept is most appropriate for discussion in our hospital medical staff sections, particularly because a medical staff could organize and enter into joint venture arrangements with the hospital or other health care institutions. The venture could involve the cooperative operation of the hospital, the operation of outpatient services in conjoined, or free standing, ambulatory centers, birthing centers, surgicenters, nursing homes, home health agencies and so forth.

Increasingly, physicians are going to be asked to put themselves at risk, to join with other institutions in horizontal integration or more dynamically in vertically integrating multi-institutional health care systems. Physicians must actively seek positions of leadership within these new institutions and make them truly partnerships so that the physicians' and medicine's viewpoints can be heard and help sustain the quality of health care for patients.

Regardless of the three or four letter acronym, regardless of whether it is solo, group practice or joint venture, let's make sure physicians are a significant part of it! Hopefully we can retain a pluralistic approach toward health care delivery in this country. The window of opportunity is open now for physicians to assume new leadership in this entire process. Physicians would be well advised to develop an understanding of, and expertise in, the business of medicine; physicians must learn about data collection systems, understand what data is currently being collected and who is analyzing it. Those individuals or institutions that collect and massage the data are going to use it to their own advantage. Data has been collected for some years now throughout the United States on length of stay by diagnosis by physician, and more data is being collected routinely on use of ancillaries and other parameters of cost. Less data is being collected on ultimate outcome

with regard to these criteria, and physicians must attempt to broaden the base of data analysis to include outcomes in terms of health and quality of life.

(6) *Seek local solutions.* The AMA and the state medical societies can provide a measure of leadership, guidance, educational programs and expert consultation that will make available an analysis of various options which could be utilized in, and applied to, local solutions. The HMSS is one such instrument. However, there is no quick fix for the problems medicine now faces; there is no magic solution for all situations; but most probably the solutions are local.

(7) *Work with hospital boards.* It is vital that physicians work aggressively and cooperatively with hospital administrators and trustees to effect appropriate solutions on the local scene. Physicians *should* be members of hospital boards of trustees; physicians should be members of every major hospital committee and must assure active participation and leadership on these committees. In many respects the age of volunteerism is over. Physicians need to be responsible and accountable for decisions made; possibly this involves payment and special incentives to physicians. There probably is no other way for physicians to be at risk.

(8) *We must develop power health care.* Access to capital will be key to successful health care systems in the future. Organization, timing and control are other factors.

Medicine has thrived largely on the concept of individual entrepreneurship, almost unparalleled in the national economy. It has been an individual, piece-work intense and labor-intense industry, with manager and worker being mostly one and the same. The physician manager has been very hard on the worker, namely himself, in terms of demanding excellence, long hours, and individual responsibility. I do not believe that full recognition of this individual labor-intensity characteristic is being factored into the future planning for manpower and budgetary analysis, with the societal change in lifestyle, with preoccupation, and appropriately so, with family life individually.

Finding Solutions

In many ways our health care dilemma may be analogous to the situation in the Middle East. If you ask President Reagan when the problem will be solved, the usual answer is, "God knows." If you ask God these days, his answer is, "Certainly not in your lifetime and probably not in mine!"

"Health care solutions are not going to happen in our lifetimes, unless we 'happen' them . . . you need to participate. Create your future and the future of medicine. Don't just sit back and have it created for you."

Health care solutions are not going to happen in our lifetimes, unless we "happen" them.

We must focus on the totality of health care, not just hospitals, or physicians, as fragments of a system. We ought to work together at continuity and comprehensiveness: birthing centers, free standing ambulatory centers and surgicenters, hospices, nursing homes, rehabilitation units and day care centers, home health care and residential living for the elderly, wellness programs and occupational health, as well as the health of our medical schools and major teaching institutions which constitute the heart bed of renewal in medicine.

Harvey Cushing said many years ago "The physician is obligated to consider not only the diseased organ and the whole person, but the person in his whole world." Indeed, that is so applicable to the problems we are now facing up to. We really need to develop a *Whole Earth Catalogue of Health Care,* and we must do it in a new partnership: physicians, hospitals, patients, industry, payors, government. Surely, we can write this *Whole Earth Catalogue of Health Care* together.

I think it was John Kennedy who said, "Everybody wants to be the Father of Victory, but Defeat is always an Orphan." As I see it, there are not going to be many victories for medicine. We have to begin to recognize that cutting our losses is sometimes tantamount to winning a victory. As Henry Kissinger has put it, "We can't solve these problems in our lifetime. We just prevent disaster." But even preventing disaster depends upon developing a proactive posture rather than reactive, in order to regain and assume more authority and responsibility for the course in medical care delivery in this country. Medical policy in this country is being decided so rapidly by agencies of the government and by the Congress and third party payers that often physicians are not consulted and have little opportunity to respond before the fact.

As Charlie Brown says, "Life is like an ice cream cone — you have to lick it." Let's have at it, and let's lick it! And this means you — you need to participate. Create your future and the future of medicine. Don't just sit back and have it created for you. ★★★

WE MADE BELIEVERS OUT OF A LOT OF PEOPLE

Seven years ago an idea was born that prompted many insurance experts in Mississippi to take notice. They laughed, they kidded and wondered how a group of Mississippi doctors could successfully form and operate an insurance company. It wouldn't succeed was the general concensus. Little did they know!

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Discouraging Marijuana Use in Young People

PATSY SILVER

PHYSICIANS PLAY a key role in education and intervention, and these are two effective ways to combat the growing problem of marijuana use among young people.

Despite the growing body of evidence concerning the hazardous effects of the drug, the frequency of use by young people appears to be increasing and the age of users is decreasing. Those facts, described in an American Academy of Pediatrics (AAP) brochure, "What You Should Know About Marijuana," combined with the fact that potency of the drug is also increasing, indicate a trend that health experts find disturbing.

According to Jackson pediatrician Dr. William F. Sistrunk, the presence of the AAP brochure in his office has elicited many questions by parents. That creates an opportunity for the physician to provide factual information, he says.

Effective presentation of the facts about the effect of the drug on their bodies is important in enabling young people to counter peer pressure, says June Milam, executive director of the Drug Research and Education Association of Mississippi (DREAM). She points out also that marijuana is termed the "gateway drug" because often it is the beginning drug among young people who go on to use others. At least one study has shown that the greater the involvement with marijuana, the greater the likelihood of multiple drug use.

A 1982 study in Gulfport indicated that among high school seniors, 27.54% had used marijuana. Among 7th graders, use was at 11.06%, and for the 8th grade, it was 15.16%.

The Gulfport study also found that the number of seniors smoking more than one marijuana cigarette a day was higher than the national average. The findings also disclosed that 22.75% of all the marijuana users began between the ages of 10 and 12.

A study of three Jackson high schools involving 2,758 students found that 59% of those using drugs were using marijuana, and 40% of those were daily users.

Concern about the problem among young people prompted the MSMA House of Delegates, at the 115th annual session, to adopt a resolution condemning the sale and promotion of the drug to minors and uring physicians to inform the citizens of Mississippi about the drug's hazards. Among the hazards noted in the resolution are:

(1) the use of mind-altering drugs or substances in immature individuals categorically inhibits emotional growth and development of decision-making skills;

(2) the use of marijuana interferes with classroom learning by impairing immediate memory and thinking, reading comprehension, and arithmetic problem solving;

(3) the use of marijuana interferes with driving and other activities which require motor skills that are developed in childhood and adolescence;

(4) because marijuana is usually smoked, there is danger that lung damage like that caused by tobacco smoking will occur;

(5) there is a reduction in sperm count and decreased sperm motility with chronic marijuana use; and

(6) regular use of marijuana causes significant changes in the psychology of the user. Frequent symptoms are mental confusion, inability to concentrate, diminished attention span, loss of will power, and difficulties with concept formation.

The American Academy of Pediatrics brochure described earlier is one of several excellent publications that are available for distribution to parents and young people. Some other titles include: "Parents: What You Can Do About Drug Abuse," "Parents, Peers, and Pot," "For Children Only," "For Parents Only," "Setting Limits," and "Marijuana Update," a reprint from the *Reader's Digest*.

Accompanying this article is a list of sources where physicians may obtain brochures for display in their offices and waiting rooms.

Information Sources

Drug Research and Education Association of Mississippi, Inc. (DREAM)
1991 Lakeland Drive, Suite B
Jackson, MS 39216 (362-9321)

Miss. Clearinghouse for Alcohol and Drug Abuse Information
1102 Robert E. Lee Building
Jackson, MS 39201 (359-1297)

American Academy of Pediatrics, Publications Dept.
P.O. Box 1034
Evanston, IL 60204 (312) 869-4255

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

The President Speaking

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

Much has been said during the past few months, particularly since the legislature has been back in session, about the poor financial condition of our state government with its shortfall of between $30 million and $100 million. New sources of revenue, ways of cutting losses, reduction of services, or raising of taxes will be necessary. Already the Mississippi "tax effort" or rate of tax collection to tax capacity is second in the southeast only to Georgia — with Georgia at 97% and Mississippi at 96%, even before the tax legislation which is now pending. This puts us in an extremely unfavorable position to attract new industry. Any increase in taxes would hurt our already poor chances.

There are several areas where cash flow, income, and savings could be improved, as listed in the Mississippi Economics Commission's pamphlet, "Managing Mississippi's Money." These include a $3 million annual improvement just by changing cash management, elimination of the state meat inspection program which reduplicates the federal program ($1 million), mandating county unit road operations ($27 million), and reduction of state government ($565 million). Instead, they attacked one of their best investments, Medicaid, even though it does not meet necessary operating cost for most physicians and other providers taking care of poor people.

In 1982, the state funded Medicaid with $69,305,978, and the federal government matched it three to one with $232,890,251. Of this, $8,372,309 was used for administration and $293,823,920 for medical services. According to figures released by the Mississippi Research and Development Center, the funding thus produced direct and indirect total personal income of $538,580,000, generated retail sales totaling $420,092,000, sales tax of $15,325,000 for the state general fund, $3,831,000 for county and local governments, and $61,937,000 in state income taxes for a total of $81,093,000 in taxes generated. That is a return of 117% of the monies funded by the state — a pretty good investment!

Another way of funding medical care for the poor is through the charity hospital system. There are only three of these hospitals in the state now which are funded out of the general fund, without federal matching monies in any amount. By their nature, they can only take care of those patients in their surrounding areas because of transportation problems, although all 82 counties in the state must support them equally out of the general fund. These hospitals receive roughly $160 per patient day, whereas the other county hospitals are reimbursed $65 per patient day for indigent care. Since no acute care hospital can care for a patient for anything near $65 per day, the losses sustained must be shifted to the paying patients; thus making those patients pay extra for their personal care, while supporting unusable facilities in remote locations. In this manner, they also subsidize the care of paying patients utilizing private care in the areas covered by the three charity hospitals. These losses are particularly hard to cover in some areas, since some of our county

(Continued on page 136)

EDITORIALS

JOURNAL OF THE
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MAY 1984

I Can Remember When . . .

It is hard to keep from saying this sometimes. I have never looked back and thought of the times when I was growing up as "the good ole times." What with the WPA, CCC, free lunches and all those others, it was barely an existence, and my memories are still too vivid to recall those days as "the good ole days."

I can well remember cancelling my room at Mississippi College in favor of pre-med at Ole Miss because my favorite uncle told me that if I studied chemical engineering I would always be working for someone else, whereas if I went into medicine I could be my own boss. So medicine it was and medicine it has been for almost thirty years. The only difference is that the "boss" has changed. I now have to answer to Medicare, Medicaid, and other third party payors. We who have ridden the crest of medicine in the 70s will be able to look back and say that we were there when medicine was at its peak. We go to many medical meetings nowadays where the main ailments discussed are those concerning our economy. Misdirected or not, times are changing and we are obliged to change with them.

I look back and wonder how I made it with a family — setting up my practice, and paying off school debts with office calls at $2.00, house calls at $3.00, and deliveries for $35.00. And yet we managed . . . and, in fact, I don't remember the difficulties so much as I recall how proud I was to be out of school finally and making as much money as I was making. But most of all I recall the joy of helping others. That joy has prevailed through all these years. It is surely one of the most satisfying and fulfilling feelings that we as doctors are privileged to know. It makes up for a lot of our current real and perceived woes.

I, too, hear some of our colleagues say "medicine is no longer any fun" and "I wouldn't want my child to go into medicine." I realize that the light of medical brilliance may have dimmed a bit, but surely we must not let it flicker and go out through our lack of interest and lack of involvement. As a group of disciplined individuals, one of our prime goals was, is, and shall be to keep our minds honed to the best medically astute edge possible in order to provide the best care for our patients. I, like you, feel some sense of guilt about throwing away a medical journal without at least giving it a good browsing. This avowed "lifetime of learning" to which we are dedicated helps us keep that flame alive; makes us want to excel; and encourages us to be the very best doctor we can be. Our patients deserve no less.

Yes, we've seen the good times . . . we've seen the bad. Let us work toward being our very best for our patients (and ourselves) so that the next generation of doctors can look back to the 80s and say "now *that* was the time to practice medicine." They might even say "I can remember when. . . . " Just think, you and I are *living* in what will be those good ole days of medicine!

Thank God I am a physician.

JOSEPH E. JOHNSTON, M.D.
Associate Editor

COMMENT

We Must All Contribute to Control The Escalating Cost of Health Care

(Ed. Note: The following remarks of Congressman Webb Franklin are reprinted from the Congressional Record *of March 27, 1984.)*

Mr. Speaker, I want to commend an organization in my state for showing great initiative and leadership in the effort to strengthen our economy and slow the escalation of health care costs.

The Mississippi State Medical Association

announced last week that it has urged its 2,100 member physicians to adopt a voluntary, one-year freeze on fees. In addition, members have been encouraged to continue the profession's long-standing practice of waiving or reducing fees for patients facing special financial difficulty — those who may be unemployed, uninsured, or covered by Medicare. The MSMA made a similar request in 1978, and the response was excellent. I am optimistic that vast majority of physicians will comply with this year's request.

There is a need for the Government and the entire medical community to work together to help control the cost of health care, and I think this is a signal of the medical profession's willingness to do so. I hope that other groups will follow the lead that the Medical Association has set, because this type of voluntary action is most helpful in continuing the economic recovery we are now enjoying.

LETTERS

To the Editors:

When I began working on the program for the 1983 annual chapter meeting of the Mississippi Chapter of the American College of Surgeons, I came across a bit of information which I think most readers in our state would find interesting, particularly those in the field of surgery. As most of you recall, we were very honored and fortunate to have Dr. James Hardy elected to the presidency of the American College of Surgeons two years ago and, although Dr. Hardy is not a native Mississippian, he has served as chairman of the Department of Surgery since the inception of the Medical Center in the late 1950s and continues to serve in that capacity. Although he is a native of our adjoining state, Alabama, the majority of his surgical contributions have been made here in our state.

As I began preparation for securing a program for our meeting, I was in contact with Dr. John M. Beal who, at that time, was chairman of the Department of Surgery at Northwestern University in Chicago. During my conversations and involvement with Dr. Beal, I became aware of the fact that he is a native Mississippian, having been born in Starkville, where his father served as a professor at Mississippi State University. At age thirteen, Dr. Beal moved with his family to Chicago where he completed his education and, subsequent to that, his mother returned to Starkville and still resides there. Dr. Beal has a son who graduated from Mississippi State University.

This information came as a surprise to me for, up until that point, I was not aware of a native Mississippian reaching the epitome of surgical honors — being elected president of the American College of Surgeons.

Dr. Beal and I discussed this, and he researched the literature and forwarded additional information to me concerning Dr. John Miller Turpin Finney. Dr. Beal found that Dr. Finney was born in Natchez, Mississippi, in June 1863. He was the second son of Rev. Ebenezer Dickey Finney, pastor of the Greenwood Presbyterian Church, and Annie Louise Parker, his wife. J. M. T. Finney graduated from Princeton on his twenty-first birthday and received his medical education at Harvard, graduating in 1889. On May 7, 1889, the opening day of the newly founded Johns Hopkins Hospital at Baltimore, he was appointed to the surgical staff by William Stewart Halstead and served there the rest of his life. He was a founding fellow and the first president of the American College of Surgeons, serving as president from 1913 to 1916. He died in 1942.

Further review of the roster of presidents from 1913 to 1983 does not indicate any other native born Mississippians who have served as president of the organization.

It has been a rather unique honor for our state to have had these two native Mississippians so honored. It is of particular interest to know that the first president of the College was a native Mississippian. In addition to the two native sons, we have also been honored by the election of our own chairman, Dr. Hardy, to this esteemed office.

I hope that our Mississippi physicians will find this bit of information stimulating and enlightening.

Benton M. Hilbun, M.D.
Tupelo, MS

Journal MSMA welcomes your comments, suggestions, and inquiries. Please address correspondence to The Editors, P.O. Box 5229, Jackson, MS 39216.

MSMA Receives AMA Membership Award

MSMA President Dr. Whitman B. Johnson, Jr., left, accepts the 1983 Membership Award presented by Dr. John J. Coury, Jr., chairman of the AMA Board of Trustees. The association received the award for exceeding its prior year membership for the seventh consecutive year.

Dr. Bower Will Head Renal Physicians Association

Dr. John Bower, professor of medicine and director of the artificial kidney unit at the University of Mississippi Medical Center, has been elected president of the Renal Physicians' Association.

Dr. John Bower

The association is a national organization with some 1,000 kidney specialists as members. Dr. Bower also has served as its vice president.

Dr. Bower has been at the Medical Center since 1965 and established one of the pioneer AKU units in the nation. He earned his medical degree at the Medical College of Virginia where he was a member of Alpha Omega Alpha and completed residency training at the Medical College of Virginia Hospital.

Dr. Bower also has served as president of the American Renal Society. He is on the medical advisory board of the National Kidney Foundation and is consultant to the End Stage Renal Disease Program for the Department of Health and Human Services. He serves as chairman of the medical advisory board of the Mississippi Kidney Foundation.

He is the author of more than 50 articles for scientific publications.

UM Medical Alumni Chapter Names New Board Members

Four new members have been appointed to the Board of Directors of the University of Mississippi Alumni Association Medical Alumni Chapter, according to Dr. Don Q. Mitchell, chapter president.

They are Dr. W. Mack Gorton, Dr. J. P. Lee, Dr. Joseph E. Varner, Jr., and Dr. Robert W. Yelverton.

Each member began serving on the board last fall and will serve for a period of three years, followed

by an additional three-year term as an associate board member.

Dr. Gorton practices internal medicine in Belzoni. He received the B.S. degree from Ole Miss in 1964, and earned the M.D. degree at the University of Mississippi Medical Center in 1968. He interned at Lloyd Nolan Hospital in Fairfield, Alabama, and completed his residency in internal medicine at University Hospital in Jackson. Dr. Gorton is a member of the American Medical Association, the Southern Medical Association and the American Society of Internal Medicine.

A native of Forest, Dr. Lee is now in family practice there. A 1964 graduate of Ole Miss, he received a B.S. degree in chemistry and earned the M.D. at UMC in 1968. Dr. Lee served a one-year rotating internship at the San Diego Naval Hospital, followed by a three-year family medicine residency program in the U. S. Navy. He also served a one-year general surgery residency at UMC. His professional affiliations include the American Medical Association, the Mississippi State Medical Association, and the Central Mississippi Medical Society, of which he is president-elect.

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Dr. Varner is a thoracic surgeon in Hattiesburg. He graduated from Millsaps College in 1961 and earned the M.D. in UMC in 1966. He completed his internship and a residency in surgery at University Hospital. Dr. Varner is a member of the American College of Surgeons, the American Medical Association and the South Mississippi Medical Society. He is presently chairman of the Department of Surgery of Forrest General Hospital.

Guardian Society Names Leaders

Gulfport psychiatrist Dr. Leonard D. Ball has been elected vice-chairman of the Guardian Society of the University of Mississippi Alumni Association.

Dr. Leonard D. Ball

The Society is a special organization which provides exceptional support for the various educational programs at the University of Mississippi Medical Center.

Dr. Rudolph A. Posey, a Philadelphia dentist, is the new chairman.

Dr. Ball, an early member of the Guardian Society, has been active in UMC alumni work for several years. He has served in leadership posts of several committees and has been a member of the Medical Alumni chapter board of directors. He is now medical director of a Gulfport hospital.

A native of Philadelphia, Dr. Posey has practiced dentistry there for 32 years. He is a past president of the Mississippi Dental Association and has served as a delegate to the American Dental Association. His UMC alumni activities, including membership in the Dean's Dental Reserve, the Dental Alumni Chapter Board of Directors and Alumni Finance Committee, of which he has served as chairman.

The Guardian Society now has a membership of more than 400 organizations, businesses and individuals sharing their resources in behalf of health professional education in Mississippi. To find out more about membership, contact the Office of Alumni Activities, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216, or call 982-9561.

New Chancellor Honored at UMC

Dr. Gerald Turner (center), newly appointed Chancellor of the University of Mississippi, was honored with a reception at the University Medical Center. At right is Dr. Norman C. Nelson, UMC vice chancellor for health affairs. Also pictured is Dr. Winfred Wiser, professor of obstetrics-gynecology and chairman of the department. Dr. Turner assumed the position April 2.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

May 17-20
CERVICAL MANUAL THERAPY
Ramada Inn, Biloxi

June 7-8
SIXTH ANNUAL NEUROLOGY SPRING SYMPOSIUM
Holiday Inn Medical Center, Jackson

Aug. 18
OPHTHALMOLOGY UPDATE 1984
Holiday Inn Downtown, Jackson

Sept. 6
BULIMIA AND ANOREXIA NERVOSA
Holiday Inn North, Jackson

For registration information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4566.

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Auxiliary President Named to AMA-ERF Committee

MSMA Auxiliary President Mrs. Stanley A. (Beth) Hartness has been appointed to the national American Medical Association Education and Research Foundation Committee, representing the AMA Auxiliary, beginning in June. Mrs. Hartness attended an orientation session in Chicago last month. AMA-ERF has gathered and distributed more than $36 million in gifts to medical schools during the past 32 years.

UMC Schedules Neurology Symposium

The sixth annual University of Mississippi Medical Center neurology symposium is set for June 7-8 at the Holiday Inn Medical Center in Jackson.

This year's symposium will focus on the neurological manifestations of metabolic, toxic and immunologic disorders. Included in this discussion are such diseases as multiple sclerosis, Guillain-Barre Syndrome, vasculitis, polymyositis, lupus, rheumatoid arthritis. Content is directed toward the practicing and academic neurologist, neurosurgeons, internist, and other medical and paramedical personnel interested in neuroscience.

Guest speakers are Dr. Robert J. Joynt, professor of neurology and chairman of the department at the University of Rochester School of Medicine and chief editor of *Archives of Neurology;* Dr. Wallace W. Tourtellotte, professor of neurology at the University of California at Los Angeles and chief of the neurology service at Wadsworth Veterans Administration Medical Center in Los Angeles; and Dr. John N. Whitaker, professor of neurology and chairman of the department at the Tennessee Health Science Center in Memphis.

Joining them are UMC faculty members Dr. Robert D. Currier, professor of neurology and chairman of the department; Dr. Owen B. Evans, associate professor of neurology and chief of pediatric neurology; Dr. Armin F. Haerer, professor of neurology; Dr. J. Eric Jordan, associate professor of neurology and chief of the EEG Laboratory of Veterans Administration Medical Center; Dr. Shri K. Mishra, associate professor of neurology and chief of neurology service of Veterans Administration Medical Center; Dr. Stephen E. Nadeau, assistant professor of neurology and staff neurologist of Veterans Administration Medical Center; Dr. J. Larry Parker, associate professor of neurology and assistant professor of surgery (ophthalmology); and Dr. S. H. Subramony, assistant professor of neurology.

This seminar is sponsored by the University of Mississippi School of Medicine Departments of Neurology and Family Medicine, the Veterans Administration Medical Center Neurology Service and the University of Mississippi Medical Center Division of Continuing Health Professional Education. Course coordinators are Dr. Mishra and Dr. Nadeau.

Course fee is $175. The program carries approximately 12.75 hours credit in AMA Category I and 12.75 prescribed hours by AAFP.

Stroke Rehabilitation Is Seminar Topic

Current trends in stroke rehabilitation is the topic of a University of Mississippi Medical Center seminar set for June 15 in Jackson.

Speakers include Dr. Armin Haerer, professor of neurology at UMC, and staff from the Mississippi Methodist Hospital and Rehabilition Center.

The program will consist of a day of lectures, followed by a panel discussion and a tour of the Mississippi Methodist Hospital and Rehabilitation Center.

Sponsors of the seminar are the University of Mississippi School of Nursing, the School of Health Related Professions Continuing Education Committee, the Mississippi Methodist Hospital and Rehabilitation Center and the Medical Center Division of Continuing Health Professional Education. Course coordinator is Dr. John D. Wofford, Sr., clinical assistant professor of medicine.

Registration fee is $45, and the American Medical Association will award 6 hours credit in Category I of the Physician's Recognition Award.

For information, contact Continuing Education at UMC, 2500 North State Street, Jackson, MS 39216-4505, or call 987-4914.

PERSONALS

John R. Bise of Jackson presented papers at the American Society for Colposcopy and Cervical Pathology and the Gynecologic Laser Society biennial meetings at Orlando, Florida, recently, and also attended a symposium at Medical College of Wisconsin in Milwaukee.

John Busey of Jackson was honored by Mississippi Baptist Medical Center when he retired recently as director of medical education.

Ben Carmichael of Hattiesburg was guest speaker at the recent meeting of the South Mississippi Medical Auxiliary.

Magruder Corban of Biloxi was named King d'Iberville of Mardi Gras.

Donald Dohn of Pascagoula was guest speaker at a recent meeting of the Mobile-Gulf Coast Chapter, American Association of Medical Transcriptionists.

Carl Evers of UMC was speaker at the 25th convention of Alpha Epsilon Delta in Birmingham, Alabama, in March.

Claude E. Fox of Jackson attended a recent board meeting of the Alan Guttmacher Institute in New York and also was a participant in the review of the Standard U.S. Birth Certificates in Washington, D.C.

Carolyn Gerald of Wiggins was speaker at the annual convention of the American Association of Medical Assistants, Mississippi Society, in Biloxi.

David N. Greenhaw announces the opening of his office for the practice of internal medicine at 208 North First Street in Booneville.

Tom Gunter announces the opening of his office for the practice of gynecology at 2102 North 5th Street, Suite 5, in Columbus.

James Hardy of UMC has been elected to honorary membership in the French Academy of Medicine. He was in Basle, Switzerland in March to attend an executive committee meeting of the International Society of Surgery.

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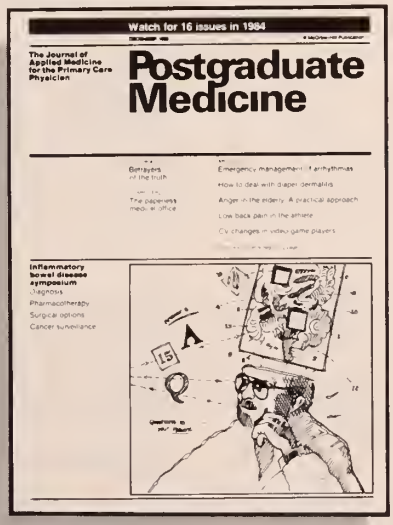

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- Emergency Medicine
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Postgraduate Medicine

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J. Ed Hill of Hollandale was recently appointed to the commission on membership and member services of the American Academy of Family Physicians.

David R. Hubbs announces the opening of his office for the practice of obstetrics and gynecology in Brookhaven.

Kelly Hutchins of Laurel was recently elected president of South Mississippi Medical Society. Dan Jones of Laurel was elected secretary-treasurer.

John Kapp of UMC presented an abstract at a March meeting of the Southern Neurosurgical Society in New Orleans.

Milton Kramer of UMC presented a paper at the Southern Sleep Society meeting in Memphis, Tennessee.

William McQuinn of Jackson recently was featured in the "Good for You!" feature of the *Jackson Daily News* for his involvement in Project Concern International.

Francis Morrison of UMC presented two lectures at a meeting of the South Central Association of Blood Banks in Albuquerque, New Mexico.

William Nicholas of UMC presented papers at the annual meetings of SCREPCIM in New Orleans and the Southern Sugar Club in Hilton Head, South Carolina, and also spoke at a diabetes seminar for family practice residents in Monroe, Louisiana.

Howard Nichols of UMC was a family practice board of examiners consultant in Lexington, Kentucky.

Phil Rhodes of UMC was featured on a recent segment of NBC's "First Camera." The show dealt with newborn intensive care.

Esteban O. Romano announces the opening of his office for the practice of adult and pediatric urology at 1018 6th Avenue in Picayune.

NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

DEATHS

Eakins, Maxine. Born Harriston, MS, Sept. 4, 1949; M.D., Michigan State University College of Human Medicine, East Lansing, 1977; interned Ohio State University Medical Center, Columbus, 1978-79; general surgery and urology residency, same, 1979-83; member of Central Medical Society, died April 3, 1984, age 34.

McEwen, Cecil Ray, Columbus. Born Brookhaven, MS, Nov. 11, 1926; M.D., Tulane University School of Medicine, New Orleans, 1952; interned Charity Hospital, New Orleans, one year; pediatric residency, same, 1953-55; member of Prairie Medical Society, died Feb. 24, 1984, age 57.

Smith, Roy Lee, Durant. Born Brookhaven, MS, July 29, 1920; M.D., University of Tennessee School of Medicine, Memphis, 1949; interned Baptist Memorial Hospital, Memphis, one year; member of North Central Medical Society, died Feb. 28, 1984, age 63.

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NEW MEMBERS

Ballard, Billy Ray, Jackson. Born Bossier City, LA, Aug. 15, 1940; M.D., Meharry Medical College, Nashville, TN, 1970; interned George W. Hubbard Hospital, Nashville, 1965-67; residency pathology, Roswell Memorial Institute, Buffalo, NY, 1967-70; elected by Central Medical Society.

Barrett, Harris Guy, Pascagoula. Born Kosciusko, MS, May 24, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family practice residency, University of Alabama and Huntsville Hospital, Huntsville, Alabama, 1980-82; elected by Singing River Medical Society.

Brewer, Martha Johnston, Jackson. Born Greenwood, MS, July 14, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and ob-gyn residency, University Medical Center, Jackson, MS, 1979-83; elected by Central Medical Society.

Brunt, Joel R., Pascagoula. Born Toledo, OH, Feb. 21, 1947; M.D., Medical College of South Carolina, Charleston, 1974; interned and internal medicine residency and nephrology residency, same, 1974-77; elected by Singing River Medical Society.

Cleland, William Howard, Jackson. Born Jackson, MS, June 20, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and ob-gyn residency, same, 1977-81; fellowship in reproductive endocrinology, Dallas, TX, 1981-83; elected by Central Medical Society.

Davis, Jacqueline O., Natchez. Born Mound Bayou, MS, Oct. 9, 1951; M.D., Meharry Medical College, Nashville, TN, 1975; interned Hurley Medical Center, Flint, MI, one year; ob-gyn residency, Providence Hospital, Southfield, MI, 1976-79; elected by Homochitto Valley Medical Society.

Gunn, Clyde H., Jr., Moss Point. Born Poplarville, MS, May 17, 1927; M.D., Emory University School of Medicine, Atlanta, GA, 1952; interned Crawford W. Long Memorial Hospital, Atlanta, one year; pathology residency, Grady Memorial Hospital, Atlanta, Jan.-July 1963; surgery residency, same, 1963-67; elected by Singing River Medical Society.

Lamb, Timothy H., Lyon. Born Greenwood, MS, July 19, 1950; M.D., Kansas City College of Osteopathic Medicine, Kansas City, MO, 1979; interned and medicine residency, Pontiac Osteopathic Hospital, Pontiac, MI, 1979-83; elected by Clarksdale and Six Counties Medical Society.

Lambert, Stephen C., Petal. Born Hattiesburg, MS, Aug. 27, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family medicine residency, University of South Alabama Medical Center, Mobile, 1980-83; elected by South Mississippi Medical Society.

Longmire, A. W., Pascagoula. Born Centreville, MS, June 1, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Walter Reed General Hospital, Washington, D.C., one year; elected by Singing River Medical Society.

Magaziner, Robert, Jackson. Born Philadelphia, PA, June 29, 1925; M.D., Temple University School of Medicine, Philadelphia, 1953; interned Valley Memorial Hospital, Johnston, PA, one year; anesthesiology residency, same, 1954-56; anesthesiology residency, University of Pennsylvania, 1956-57; elected by Central Medical Society.

Miller, Thomas P., Morton. Born Muncie, IN, Aug. 8, 1951; M.D., Indiana University School of Medicine, Indianapolis, 1977; family practice residency, St. Joseph's Hospital, South Bend, IN, 1977-80; elected by Central Medical Society.

Mulholland, David H., Jackson. Born Greenville, MS, July 29, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, University Medical Center, Jackson, MS, 1980-83; elected by Central Medical Society.

Myers, Robert P., Starkville. Born Hazlehurst, MS, Jan. 25, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and medicine, surgery, and urology residency, same, 1978-83; elected by Prairie Medical Society.

St. Romain, Ray A., Pascagoula. Born New Orleans, LA, Nov. 25, 1927; M.D., Louisiana State University School of Medicine, New Orleans, 1956; interned and ob-gyn residency, Charity Hospital, New Orleans, 1956-60; elected by Singing River Medical Society.

Announcing newly formulated

Equagesic®

(meprobamate with aspirin) ℞ Wyeth

New tablet

Proven more effective than aspirin alone in controlled clinical trials

See important information on next page

Equagesic®
(meprobamate with aspirin) © Wyeth

Effective adjunct in short-term treatment of pain
accompanied by tension and/or anxiety in patients with musculoskeletal disorders.

when anxiety magnifies the perception of pain

1-2 tablet dosage 3 or 4 times daily

Equagesic®
(meprobamate with aspirin) © Wyeth

(BRIEF SUMMARY)

DESCRIPTION:
Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED:
Scored tablets, bottles of 100; Redipak® strip pack 25's, Redipak® unit dose 100's, individually wrapped.

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Philadelphia Pa 19101

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Counsel to Authors

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Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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Roche salutes
the history of Mississippi medicine

SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.[1]

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites far contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An ero af specialists, chap 5, in Lee RV, Eimerl S *et al* *The Physician* New York, Life Science Library, Time Inc., 1967, pp 107-109

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ROCHE

When the history reveals mixed depression and anxiety...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,[1] Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl/Roche), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs which has been associated with tardive dyskinesia.

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME, New York, Appleton-Century-Crofts, 1977, p. 316 **2.** Feighner JP *et al*: *Psychopharmacology 61* 217-229, Mar 1979 **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® Tablets Ⓒⅳ Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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Medico-Legal Brief

Optometrist Loses Libel Suit Against Organization

A nonprofit organization of ophthalmologists had a qualified privilege to publish information relating to treatment given by an optometrist, a Michigan appellate court ruled.

In a newspaper distributed to ophthalmologists and other interested persons, including government officials, the nonprofit organization published an article concerning the optometrist's treatment of an oral surgeon. The article, which did not contain the optometrist's name, charged him with professional negligence and attributed the oral surgeon's vision loss to the optometrist's response to the oral surgeon's problems. The optometrist contended that the article contained numerous misstatements as the oral surgeon's condition and his own conduct and that as a result of the publication his professional reputation had suffered greatly.

The optometrist brought an action for libel against the organization. The trial court found that the allegedly libelous statements had been cloaked with a qualified privilege and that the organization was entitled to a directed verdict because the optometrist had not presented evidence of actual malice.

On appeal, the appellate court said that in order for a private person to recover for an allegedly defamatory statement in the media concerning matters of public interest the person must prove that the statement was published with the knowledge that it was false or with reckless disregard as to whether or not it was false. The court affirmed the trial court's finding of no evidence of actual malice. — *Gaynes v. Allen*, 339 N.W.2d 678 (Mich.Ct. of App., Aug. 16, 1983)

The President Speaking

(Continued from page 122)

hospitals carry a census of 60-65% government pay patients to which there can be no cost shifting under DRG's, and 20% are charity; this leaves only 15-20% paying their way. In 1980, $3.48 million was appropriated to run these three charity hospitals; in 1983, $5.6 million; and for 1984 and 1985, $6.4 million and $7.04 million have been requested. So the charity hospitals are feeling the pinch of inflation like everyone else.

In these days of cost containment and consumer consciousness how much longer can these differences continue to exist without public scrutiny? Then perhaps our medically indigent as well as our taxpayers can be treated on a more equitable basis throughout the state. ★★★

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi, Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties. Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38665. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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Jackson, MS 39216

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830 Gloster Avenue
Tupelo, MS 38801

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Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N State Street
Jackson, MS 39201

Gulf Coast Community Hospital
4642 W Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Delta Medical Center
P.O Box 5247
Greenville, MS 38701

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
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NATIVE MISSISSIPPIAN completing pediatric residency in July 1984 seeks location in state. Contact Tom Ireland, M.D., 3516 Casawoods Lane, Clarkston, GA 30021; (404) 296-2940.

BOARD CERTIFIED internal medicine physician seeks location for small rural practice. M.D. from Johns Hopkins University. Contact Edwin B. Struve, M.D., 29 Dellwood Avenue, Chatham, NJ 07928.

ANESTHESIOLOGIST seeks practice location. Box A, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

GENERAL SURGEON seeks relocation in Mississippi. Box S, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

OTOLARYNGOLOGIST currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

BOARD CERTIFIED FAMILY PRACTITIONER seeks location in Jackson or Greenville area with established group beginning August 1, 1984. Contact Hernando C. Payne, M.D., 1557-A Eglin Way, Washington, DC 20336.

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IN CONCLUSION

Hot dogs are the food most often associated with fatal childhood asphyxiation, according to a new study published in the May 4 JAMA. The researchers studied records of 103 infants and children whose deaths were attributed to specific foods, and found hot dogs accounted for 17%. Others included candy, nuts, grapes, apple pieces, cookies and biscuits. The highest incidence of food asphyxiation was among one-year-olds. The number of deaths from food asphyxiation is of the same magnitude as the number of childhood deaths from poisoning.

Computerized information services have been developed by the AMA in conjunction with the CDC and the FDA. The CDC uses MED/MAIL, the electronic messaging service of the GTE Telenet Medical Information Network, to transmit disease alerts, to list training courses offered to physicians, and to report recent developments in the treatment of diseases such as AIDS and toxic shock syndrome. The FDA uses the system for physician reporting of Form 1639, which speeds up by several days reporting of adverse drug reactions.

The end of rubella is predicted in two major articles in the April 20 JAMA. In one, the author says the elimination can be accomplished by vaccinating women of childbearing age and children enrolling in schools, intensifying surveillance for both acquired rubella and congenital rubella syndrome, and by aggressively controlling rubella outbreaks. An editorial in the same issue asserts, "The only stumbling block to the elimination of rubella syndrome is the apathy or resistance of physicians."

"The best PREVENTION is ABSTENTION." That is the advice the American Medical Association is giving pregnant women who ask, "Will drinking hurt my baby?" A new booklet, "Alcohol & Pregnancy: Why They Don't Mix," explains how alcohol can damage a fetus. A single copy may be obtained free by writing to Health Education, AMA, P.O. Box 10947, Chicago, IL 60610. For information on prices for multiple copies, write to the Order Department, AMA, 535 North Dearborn Street, Chicago, IL 60610.

Oral theophylline preparations can produce potentially serious intoxication, according to a report in the April Archives of Internal Medicine. "Toxic effects occurred in older subjects with poorly reversible airflow obstruction and evidence of reduced theophylline clearance," the researchers said in the report of 22 episodes. "Toxic effects appear to result from incomplete understanding by both patient and physician..." the authors said. They urged cautious use of the compound and alertness for drug interactions.

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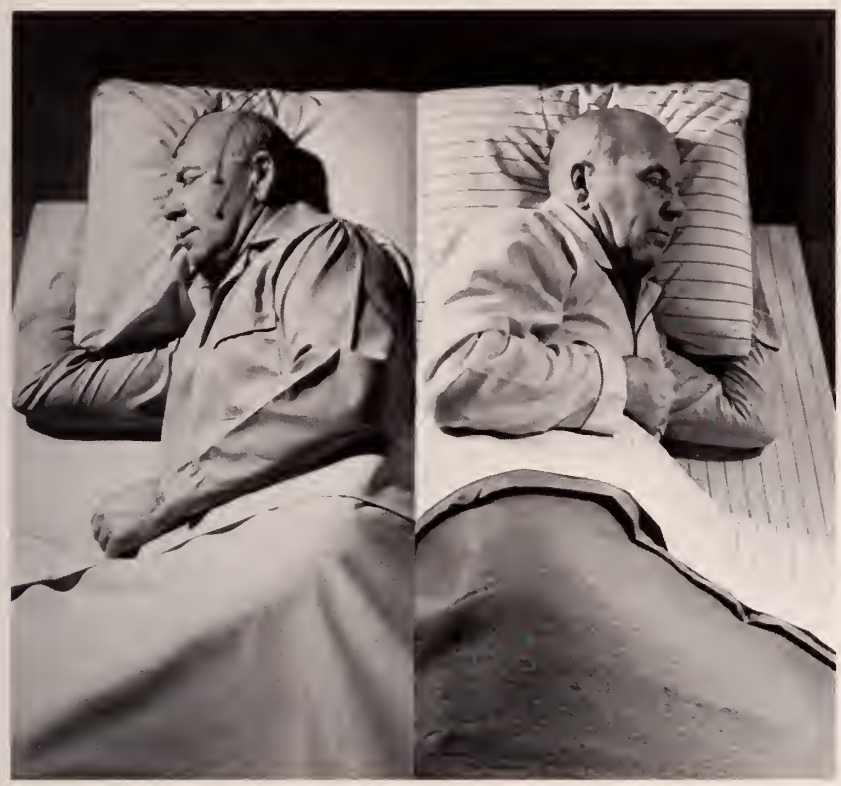

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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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June 1984

JOURNAL of the MISSISSIPPI State Medical Association

Ellis M. Moffitt, M.D. — MSMA President, 1984-85

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NEWSLETTER

June 1984

Dear Doctor:

Congressman Wayne Dowdy has sponsored an AMA-backed bill to define the term "physician" under Medicare. The bill calls for physicians to be defined as doctors of medicine or osteopathy. Through the years Congress has expanded Medicare benefits by expanding the definition of "physician."

> Last year regulations were provided to acknowledge this expansion by calling all Medicare providers "physicians." In introducing the legislation, Congressman Dowdy said he was trying to return to a dictionary definition of the term and to clarify "a confusing state of affairs."

A modified version of a controversial organ procurement and transplantation proposal was reported by the House Energy and Commerce Committee. The bill deletes amendments to the Medicare program that were opposed by the AMA and other groups. Those amendments would have granted to the secretary of HHS new authority to deny Medicare reimbursement to all but selected patients, practitioners, and institutions for any health care technology or procedure, and not only for transplants.

Last month a federal judge granted the AMA's request to invalidate the HHS "Baby Doe" regulations. The AMA, in a public statement, expressed "elation" with the ruling, and also reaffirmed the association's position that the care of newborns should be the responsibility of the parents, in consultation with physicians and other professionals on the medical treatment team.

Substitution of three levels of surgery terminology (minor ambulatory, major ambulatory and inpatient) for the current two levels (inpatient and outpatient) would benefit patients, physicians, reimbursement agencies, planners and others, says a physician writing in the May 18 issue of JAMA.

Next month in Journal MSMA there will be a complete report on the 116th Annual Session, including a summary of actions of the House of Delegates and a pictorial review of the week's events.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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DATELINE

Medicaid Fraud Control Unit Is Created

Jackson, MS - Among health related bills passed by the 1984 Mississippi Legislature was one creating a Medicaid Fraud Control Unit in the attorney general's office. The Fraud Unit is given broad authority to investigate complaints concerning services provided to Medicaid recipients and to prosecute instances of abuse in this regard. Complaints may be made by calling 359-3166 or by writing Medicaid Fraud Unit, Box 56, Jackson, MS 39205-0056.

Bill Suggests Tougher Cigarette Warnings

Washington, DC - Tougher cigarette warnings would be mandated under a bill approved by the House Energy and Commerce Committee. Four warnings would be rotated on cigarette packages and advertisements. The labels include: a warning that smoking causes lung cancer, heart disease and emphysema; a warning to pregnant women; advice that quitting smoking reduces health risks; and a warning that cigarette smoke contains carbon monoxide.

Vaccine Not Implicated As Factor in MS

Chicago, IL - A new study from the Mayo Clinic suggests that the epidemiologic features of multiple sclerosis do not implicate swine flu vaccine as a causal factor of the disease. Writing in the May 25 JAMA, the authors point out that the naturally occurring new cases among the 45 million vaccine recipients is estimated at 1,642 during the year after vaccination. Information shows no excess over the expected frequency.

Physicians Support Fee Freeze

Chicago, IL - The voluntary fee freeze is being supported by 80% of the nation's physicians, reported the AMA at a press conference. "This doesn't mean that American doctors are simply not increasing their income but that they are losing $9,000-$12,000 a year because their overhead is going up," said Dr. Joseph F. Boyle. The one-year moratorium will reduce the nation's medical bills by $3.5 million or 1% of the total, he added.

Prescription Drug Ads to Consumers

Chicago, IL - Prescription drug advertising to consumers was opposed in a statement adopted by the AMA Board of Trustees. The AMA had earlier testified that physicians are concerned about the possible effects of such advertising on their ability to select the most appropriate drug for their patients. The FDA has asked for a moratorium on any further direct advertising to the public until it can establish a regulatory policy.

A WORD TO THE WHYS

WHY AMA? Thanks to the Patient Medication Instruction program newly launched by the AMA, you can provide your patients with important supplementary drug information. Each patient information sheet (PMI) conveys information most relevant to the patient in easy-to-understand language. Helping your patients toward a better understanding of the drugs you prescribe: it's one more good reason why you should be a part of the AMA.

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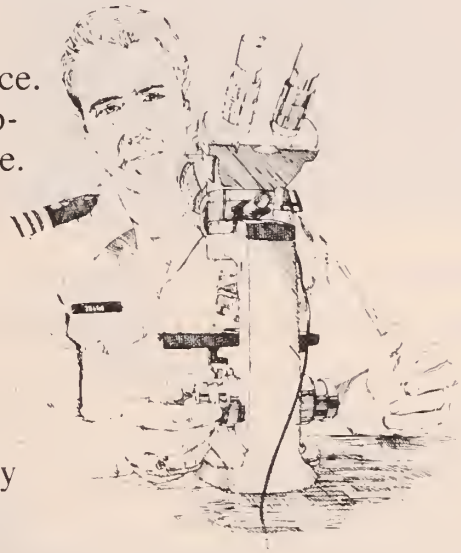

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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JOURNAL OF THE MISSISSIPPI MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Pulmonary Mycetomas

W. WILSON DEFORE, JR., M.D.
Jackson, Mississippi

ASPERGILLOSIS is a widespread mycotic infection due to species of the dimorphic fungal organism *aspergillus*. The primary etiologic agent in human disease is *Aspergillus fumigatus*, but *A. flavus*, *A. niger*, *A. nidulans* and *A. clavatus* have also been reported. *Aspergillus* species occur in the human host as saphrophytes of the upper respiratory tract, especially in patients with chronic pulmonary diseases such as tuberculosis, histoplasmosis, chronic abscesses or cavitary carcinomas. Intracavitary mycetomas result from secondary colonization by *aspergillus*.

When this saphrophytic organism invades the human host, there is commonly underlying pulmonary disease or reduced host defense mechanisms. The recognition of the common association of mycetomas with massive hemoptysis has added additional importance to this entity.

The following is a case report of a patient with pulmonary mycetoma and a review of the medical and surgical treatment of this interesting fungal condition.

Case Report

W.G., a 54-year-old black male, was initially seen in 1979 for treatment of tuberculosis. The patient was treated with INH and ethambutol and followed with regular clinical visits. In May 1981, the patient was admitted to the hospital with complaints of a chronic cough, hemoptysis, weight loss, lethargy and anorexia. Physical examination at this time revealed a thin, chronically ill-appearing man with diminished breath sounds over the right upper chest, and scattered pulmonary rales. Admission chest x-ray showed a rounded opacity in the right upper lobe with a crescent-shaped radiolucent area superior to the mass. Changes in the position of the patient resulted in movement of the density of the intracavitary mycetoma. Tomograms of the right upper chest confirmed the presence of an intracavitary mycetoma. Preoperatively, the patient was noted to have a positive Argar gel test for *aspergillus*.

On June 1, 1981, the patient underwent a right thoracotomy with resection of the right upper lobe. The operative specimen revealed a reddish-brown friable mass within the right upper lobe cavity, and pathologic section showed a cavitary lesion with marked parenchymal destruction, and pulmonary emphysema with an intracavitary mycetoma. Portions of the wall of the cavity and fragments of the fungus ball were submitted for microbiologic examination. *Mucor*, *Candida*, and *aspergillus* were additionally cultured from the operative specimen. Postoperatively, the patient had an uneventful course, and anti-tuberculous medications were continued.

Discussion

Primary infection with *aspergillus* is rare, the more common disease pattern in the human host being secondary aspergillosis. *Aspergillus* infection in the patient with chronic cavitary lung disorders is seen more frequently. The classification of secondary aspergillosis includes: (1) saprophytic, in which

The author is engaged in the private practice of surgery in Jackson, MS.

chronic cavities are colonized by *aspergillus* with formation of mycetomas; (2) hypersensitivity or allergic aspergillosis with an asthmatic-like syndrome with an airway disorder accompanied by wheezing and cough; and (3) disseminated or opportunistic aspergillosis (invasive-type), with systemic pulmonary diseases with abscesses and granulomas, especially in those patients with immunosuppressed status due to steroids, chemotherapy, or antibiotics as in connection with renal or cardiac transplants, or hematologic and lymphatic malignancies.

The first report of aspergillosis was by Sleyter in 1874, and the original description of a mycetoma was made by Deve in 1938. The first reported successful resection of a pulmonary mycetoma was by Gerstl in 1946.

Grossly, a pulmonary mycetoma is a conglomerate of fungal hyphae intertwined with fibrin and mucoid material with cellular debris. The mycetoma most commonly occurs in a pre-existing cavity formed by tuberculosis, but it may also be associated with chronic abscesses, carcinomas, sarcoid, bronchial cysts, bronchiectasis, pulmonary infarcts or other fungal diseases. The frequency of aspergilloma formation in patients with cavitary chronic lung disease is reported at 10% to 15%. The fungus is usually present as a saphrophyte with rare evidence of invasion of the cavitary wall of the host. The opportunistic infection commonly presents in patients with altered body defense mechanisms. Those patients with predisposition to mycetoma formation include those with depressed antibody and cellular defense mechanisms, such as patients with malignancy, a prolonged use of antibiotics or corticosteroids.[1]

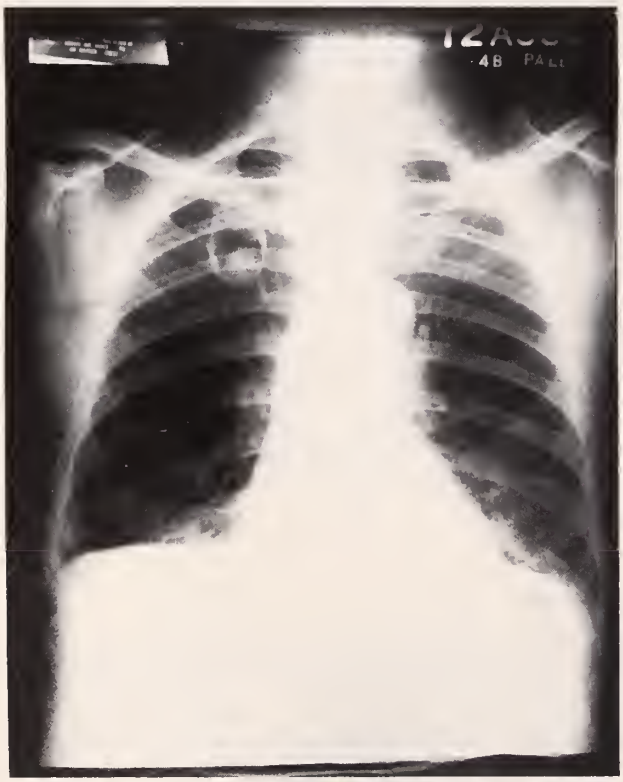

Figure 1

The diagnosis of mycetoma is suggested by the findings or positive precipitative antibodies against *aspergillus* antigens, which can often be demonstrated in patients with aspergillomas. These generally revert to negative several months after resection. With potent antigen, positive skin test reactions have been reported in approximately 20% of the patients with aspergillomas due to certain strains. Arthus skin reactions, however, are rarely seen in association with pulmonary mycetomas. If the involved cavity is in proximity to an open bronchus, the organism may be cultured from the sputum.

Pulmonary mycetomas present a characteristic radiologic picture with a spherical mass density in an ovoid cavity, distinct from the wall of the cavity by a crescent-shaped air space superiorly (see Figure 1). The fungus ball characteristically moves with the change in the position of the patient, and is verified by tomography. Fungus balls most often present in the upper pulmonary lobe, due to the high incidence of association with pulmonary tuberculosis. The cavities are characteristically thin-walled and small, and are frequently near the markedly thickened pleural surface.

The differential diagnosis in a patient with suspected pulmonary mycetoma includes necrotizing carcinoma, acute or chronic lung abscess, decomposing hydatid cyst, and cavitary blood clot.

Clinically, the majority of the patients with intracavitary mycetomas present with recurrent hemoptysis, which may become massive as a result of erosion of a blood vessel in a pre-existing cavitary lesion. Hemoptysis has also been ascribed to endotoxin formation with hemolytic activity in these patients, as well as a trypsin-like proteolytic enzyme elaborated by the aspergillus organism. The patients also may have a productive cough, chills and fever, weight loss, anorexia, or pulmonary infiltrates. Physical examination usually reveals hyperresonnance over the cavitary lesion with wheezes and audible rhonchi on auscultation of the chest.

Hemoptysis is present in approximately 40 to 70% of patients with pulmonary mycetomas, and is the

determining factor in the decision for surgical treatment. It is generally agreed that the involved pulmonary lobe should be surgically resected in the patient with copious or massive hemoptysis to avoid progression to terminal exsanguination. The experience of some investigators with the high incidence of often fatal hemoptysis has led them to advocate surgical resection in any patient with pulmonary mycetoma who is an acceptable candidate. Appropriate resections may include pneumonectomy, lobectomy, segmentectomy, wedge resection and occasional use of thorocoplasty. Surgical complications following resection of the mycetoma include broncho-pulmonary fistula, residual space lesion, air leak, bleeding and infection. Mortality in the patients who undergo surgical resection for mycetoma is approximately 7%.[2, 3] Historically, systemic Amphotericin B, or other antifungal agents as sodium iodide, nystatin, and hydroxystilbanidine have not proved effective in the medical management of mycetomas. However, endobronchial or endocavitary irrigation of the involved site with amphotericin B introduced endobronchially, or percutaneously, may be effective in the chronically debilitated patient unable to undergo surgery, or in the patient who refuses surgical therapy. In addition, unresectable disease with major bleeding may be palliated by use of bronchial arterial embolization through a percutaneously placed catheter.

Empyema formation as a result of *aspergillus* has been managed with thorocostomy tube drainage, thorocoplasty or intrapleural instillation of nystatin or amphotericin B, and occasionally with parenteral administration of amphotericin B or 2-hydroxystilbanidine.[4]

Summary

Aspergillosis is a conglomerate of pulmonary infections by members of the genus Aspergillus and causes a variety of manifestations in the human host. Aspergillus fumigatus is the most common organism associated with the disease in man. The classification of clinical syndromes associated with aspergillus include pulmonary mycetoma, broncho-pulmonary allergic aspergillosis, invasive aspergillosis, and disseminated forms. The diagnosis of pulmonary mycetomas is supported by the clinical presentation with hemoptysis, positive precipitan skin test, and the characteristic chest x-ray findings.

Mycetomas generally require surgical treatment when there is evidence of recurrent or progressive hemoptysis. With copius bleeding, surgical resection of the involved pulmonary lobe is generally indicated unless the patient is too debilitated. Unfortunately, resectional therapy is precluded in many patients by the underlying nature of the primary disease, and these patients will occasionally respond to irrigation of the cavity with Amphotericin-B introduced endobronchially or percutaneously or broncheal arterial embolization. ★★★

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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur, transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

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J-4044 January 1984

New Concepts in the Management of Venous Varicosities and Stasis Ulceration

SESHADRI RAJU, M.D.
Jackson, Mississippi

THE RECENT INTRODUCTION of new devices and techniques to study the venous system of the lower limb is providing new insights into the pathophysiology of varicosities and stasis ulceration.

Conventional Theory and Practice

Trendelenberg's theory of saphenofemoral valve incompetence is widely accepted as a major mechanism of varicose formation. Linton, Cockett, and others[1] have strongly challenged this view, placing primary emphasis on perforator incompetence instead as the primary mechanism. Saphenofemoral valve incompetence when present is viewed by the latter authors as a secondary phenomenon caused by the dilatation of the saphenous vein from perforator incompetence. However, most surgeons in this country and elsewhere tend to practice saphenous vein stripping as the preferred surgical procedure for "primary" varicosities. The Linton procedure for ligating "blowouts" below the knee is usually reserved for stripping failures and recurrences. Before resorting to surgery for varicosities, a venogram is usually performed to rule out deep vein thrombosis and "secondary" varicosities. Neither Trendelenberg nor Linton attempted to explain the failure of a venous valve at an isolated anatomical location.

The etiology of venous stasis ulceration is not clearly understood, as evidenced by the variety of surgical approaches in current use for this commonly prevalent condition. Saphenous vein stripping, perforator ligation or sclerotherapy, and skin grafting are among the numerous techniques currently in vogue. Most commonly, however, a conservative approach is taken with elevation, stockings, or application of Unna Boot. There is a substantial recurrence and failure rate with all of these methods.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

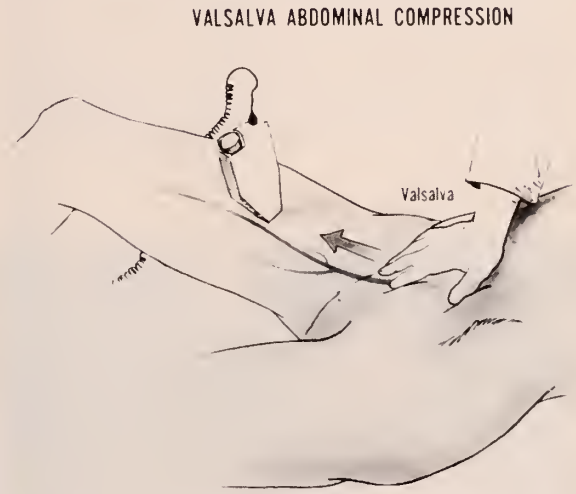

Figure 1. A Doppler probe can detect retrograde venous reflux. Figure shows Valsalva maneuver with manual abdominal compression being used to elicit retrograde flow.

New Techniques

The venous system of the lower limb can now be studied in detail with a variety of noninvasive and invasive techniques (see Figures 1 and 2):

A. Impedance Phlebography[2] detects obstruction of the venous system based on electrical impedance of calf volume.

B. Venous Doppler[3] examination (Figure 1): With a hand held Doppler probe, a variety of information from reflux to obstruction can be elicited. Variations from normal respiratory waves present in the venous system and the response to proximal and distal manual compression, to detect reflux or obstruction can be monitored (Figure 1).

C. Photoplethysmography[4] (Figure 2): Cutaneous venous congestion of the lower leg is measured by

this photosensitive probe. When a tourniquet is used, this test is often utilized to differentiate perforator incompetence from saphenofemoral incompetence.

D. Ambulatory and Resting Venous Pressure Measurement[4]: With a needle in a dorsal foot vein, this technique can often yield valuable information about the venous pressure relationships existing in the superficial and deep venous systems of the lower limb. Specifically, it is often possible to differentiate venous obstruction from reflux and superficial from deep venous insufficiency.

E. Ascending and Descending Contrast and Nucleotide Venography (see Figure 3): The basis of venous reflux can be examined and quantitated by descending venography. Intact leaky valves as well as destroyed valve apparatuses can be visualized and localized.

TABLE 1

Type of Venous Insufficiency in 136 Limbs Tested

Superficial venous insufficiency alone	0%*
Combined superficial and deep venous insufficiency	27%
Isolated deep venous insufficiency	73%

* One patient had isolated saphenofemoral incompetence by Doppler.

New Insights

Utilizing the newer techniques, 136 limbs in patients with stasis ulceration or suspected venous insufficiency were studied in detail (see Table 1). Even though 14% of these patients had varicosities, it was remarkable that pure "primary" varicosities were not detected even in a single patient (with one arguable exception, as noted). In every instance, when superficial varicosity was present, deep venous incompetence could be detected by one or more of the techniques employed. Even more sur-

Figure 2. A photoplethysmograph device (PPG) can detect cutaneous congestion from venous insufficiency. Tourniquet application differentiates superficial from deep venous reflux.

Figure 3. Descending venography demonstrates reflux through grossly incompetent valves in the femoral region.

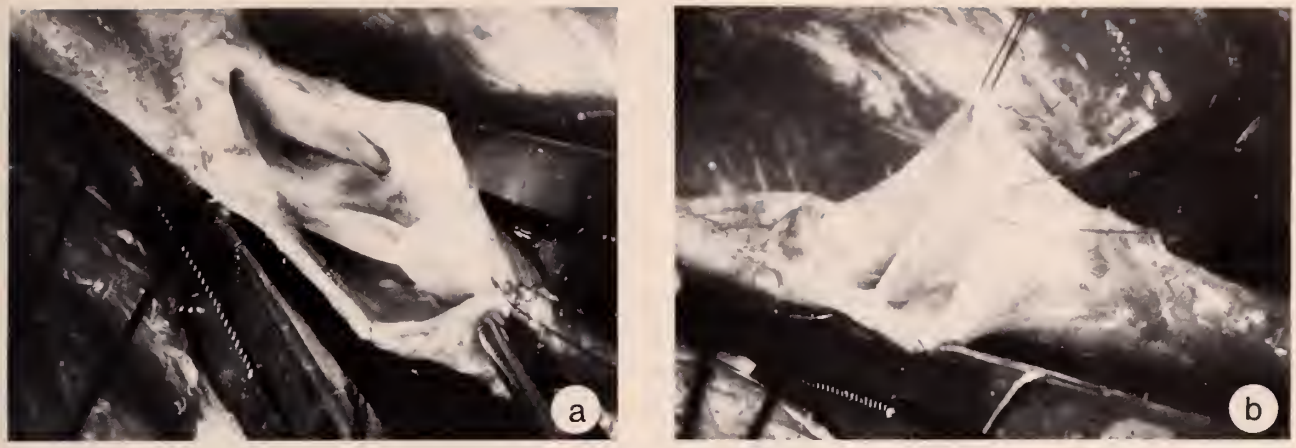

Figure 4. (a) Redundant venous valve of superficial femoral vein just below profunda orifice; (b) tightened valve cusp following valvuloplasty. Patient's head is to the left. The profunda orifice is well visualized in 4a but somewhat hidden by the repaired valve cusps in 4b.

Figure 5. Healing of stasis ulceration following valvuloplasty.

prisingly, the incidence of isolated deep venous insufficiency or reflux was very high in this group of patients. Such a high prevalence has not been suspected heretofore. These findings appeared to indicate that unsuspected deep venous insufficiency was the major pathological mechanism that initiated perforator incompetence as well as saphenous varicosities.[5] Furthermore, several characteristics of this deep venous system reflux appear to cast doubt upon the conventional view that deep venous insufficiency is invariably due to phlebothrombosis of the deep venous system. It appears that venous valve incompetence is a generalized phenomenon[5] present in diverse locations of the body, including the upper limb. A congenital defect in valve tissue is suspected.

Direct Valve Surgery

Based on this evolving concept, 59 patients to date have undergone direct venous valve surgery. Most commonly, a valvuloplasty of the first valve in the superficial femoral vein (see Figure 4) has been employed. Less commonly, a valve-bearing segment from the axillary vein ensheathed in a Dacron sleeve has been transposed to the femoral vein.

With a follow-up ranging from three months to three and one-half years, results of reconstructive valve surgery have been considered excellent in 79% of 38 operated limbs.[5] Results have been impressive among patients with chronic venous pain as well as stasis ulceration (see Figure 5). Some recalcitrant ulcers of long duration resistant to conventional

forms of therapy have healed. Relief of chronic swelling appears to be less certain with this surgical approach, however. The durability of the results obtained with direct valve surgery is currently under careful evaluation in our institution.

Summary

Recently introduced devices and techniques to study venous insufficiency of the lower limb are changing traditional concepts and views in this area. Based on new insights, direct venous valve surgery was performed in 59 patients. Initial results of this direct approach to venous insufficiency appear promising. In some patients, long-standing ulcers recalcitrant to other forms of therapy have healed for the first time with this surgical approach. The durability of relief from venous insufficiency obtained with direct valve surgery is currently under evaluation.

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Histiocytic Lymphoma With Invasion of Renal Vein and Vena Cava: A Case Report

JOHN P. ELLIOTT, JR., M.D., JAMES O. GORDON, M.D.,
JOHN W. EVANS, M.D., LUCAS O. PLATT, M.D., and WILLIAM HUGHES MILAM, M.D.
Tupelo, Mississippi

A 68-YEAR-OLD white male, retired farmer, was referred with one day's duration of total gross painless hematuria. Urological examination was essentially within normal limits, except for a slightly enlarged, but benign, prostate. Intravenous pyelogram revealed a non-functioning right kidney. Cystoscopy and right retrograde pyelogram (see Figure 1) revealed obstruction just below the ureteropelvic junction, which appeared to be extrinsic in nature. A CT scan (see Figure 2) revealed a large retroperitoneal solid mass involving the lower pole of the right kidney with possible involvement of the renal vein and inferior vena cava. Renal arteriogram (see Figure 3) revealed essentially normal renal vasculature with no intrinsic renal lesion. An inferior venacavagram (see Figure 4) revealed a large defect projecting into the vena cava at the level of the renal vein and extending almost the full width of the vena cava. Blood count and SMA-18 were normal. A right radical nephrectomy with removal of all adrenal tissue and vena caval lymph nodes to the level of the diaphragm was done. There was a large volume of right renal vein and vena caval tumor extension, necessitating control of the left renal vein and vena cava above and below the lesion.

Because patching of the vena cava was contemplated, a vascular surgery consult was obtained. After heparinization, the lesion was removed with part of the lateral wall of the vena cava. Repair caused vena cava narrowing, but vena cava patching was unnecessary as tumor growth did not involve the wall of the vena cava as extensively as anticipated. This has been our experience with hydronephroma involvement of the vena cava, also. Collateral flow from the left renal vein was quite adequate. The urine output did not decrease during the procedure. The pathology report revealed malignant lymphoma, histiocytic type, involving the right kidney and

Figure 1. Right retrograde pyelogram revealing lateral deviation and obstruction of the ureter at the L-3 level.

The authors are engaged in the practice of urology in Tupelo, MS. (This article was submitted in August 1983.)

proximal ureter with invasion of the renal vein and vena cava. The patient's wound healing and postoperative course proceeded normally, and he received his first course of chemotherapy on the fifteenth postoperative day. This was continued by the hematology consultant for 16 weeks. The patient is alive and without evidence of disease at 18 months.

Figure 2. CT scan showing mass contiguous with right kidney.

Medical Observation

The urinary tract is the most frequent site of systemic malignant lymphoma involvement outside the hematopoietic system and should be considered anytime extrinsic encroachment on the urinary tract is detected radiographically.[1, 2]

Social Observation

It has been our experience that most patients are better served having one physician, as multiple physicians can fragment patient care. Using the one primary physician philosophy, however, the multidisciplinary approach can achieve excellent results perhaps not achievable otherwise. The disciplines involved in this patient's care were as follows: family practice (the patient interrupted his hospitalization to go home and confer with his family physician), urology, internal medicine, vascular surgery, radiology, pathology, anesthesiology, hematology and oncology.

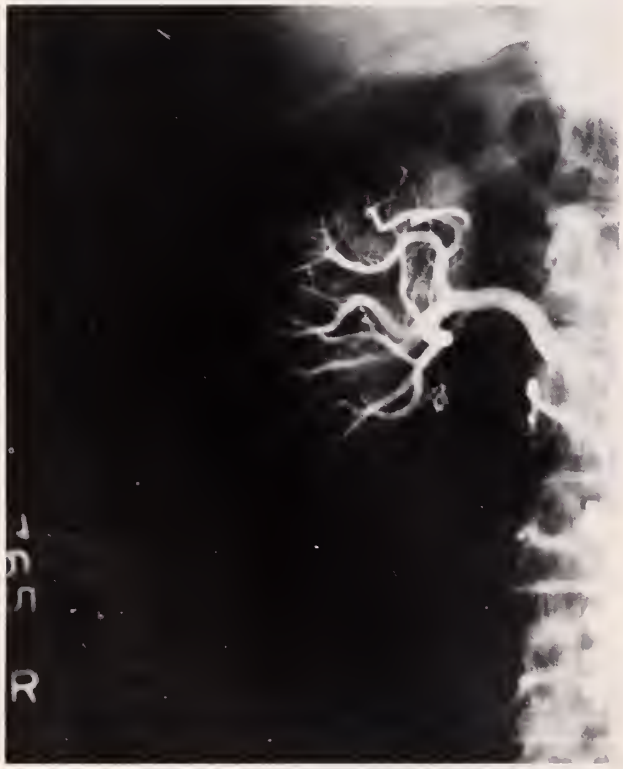

Figure 3. Right renal arteriogram demonstrating normal architecture with no intrinsic renal mass.

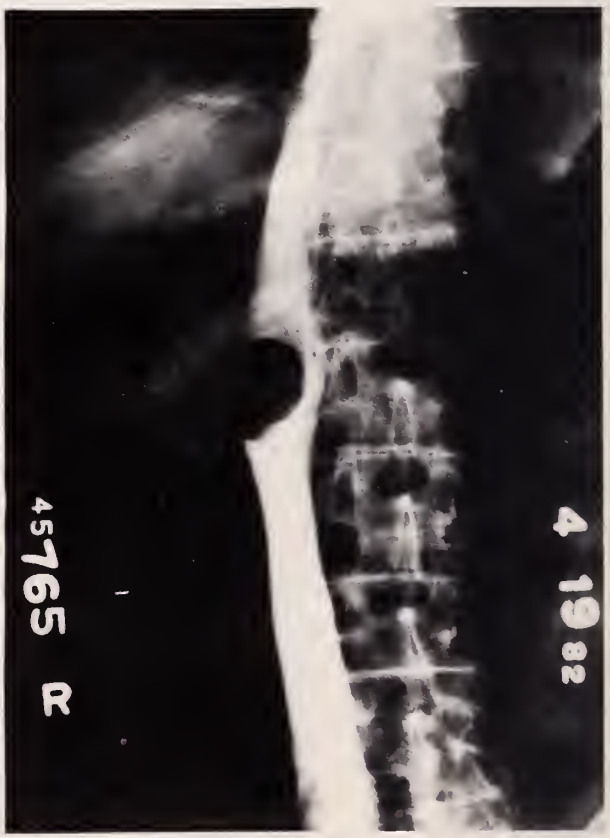

Figure 4. Inferior venacavagram revealing renal vein and vena cava invasion.

Economic Observation

In this new era of compensation, hospitals are being paid according to diagnostic related groups instead of for "service rendered." If reimbursement of physicians eventually is included, it will necessitate a division of one payment among the hospital and all doctors involved in the patient's care. If this occurs, the doctor will be placed in the dilemma of making a personal economic sacrifice any time consultation with another physician is needed. Obviously, only the third party payor would benefit. The practice of specialty medicine would suffer substantially.

> "It could be so, that saying I heard, that the subject of worry we most rue not only rarely comes true, but is usually downright absurd."

I hope so. ★★★

605 Garfield Street (38801)

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SPECIAL ARTICLE

Radiologic Seminar CCXXXVIII: Mammography — Benefit and Risk

JOHN EVANS, JR., M.D.
Jackson, Mississippi

BREAST CANCER is both the most common cancer and the leading cause of cancer deaths in women. There will be 112,000 new cases in the United States in 1984 and about 37,000 women will die of the disease. One in eleven women can be expected to develop the disease during her lifetime.[1]

The results of improved treatment strategies have been offset by slightly higher incidence so that the overall death rate from breast cancer has not changed since 1930. Since the cause of breast cancer is not known, the best hope of significantly reducing mortality rates would seem to be earlier diagnosis.

The benefits of early diagnosis have already been shown. In the 1960's, a screening program conducted by the Health Insurance Plan of New York (HIP) evaluated 31,000 women with mammography and by physical examination for five successive years. A 33% reduction in mortality was observed in the screened group compared with the control population.[2]

The role of mammography in the early diagnosis of breast cancer has more recently been redefined by an ongoing program sponsored by the American Cancer Society and the National Cancer Institute. Beginning in 1973, 280,000 women were evaluated by physical examination and mammography at yearly intervals for five years in the Breast Cancer Detection Demonstration Project (BCDDP). Of the 3,550 cancers detected by the BCDDP, 32% were less than one centimeter in size and over 80% showed no evidence of nodal involvement. Mammography's favorable influence on survival can be inferred from the fact that 50% of the cancer detected without nodal metastasis were not palpable. If mammography had not been added to the screening protocol, one-half of the cancers in the best prognostic category would not have been detected until they were larger, when many would have reached a more advanced state.[3]

A second recent report also supports the contention that mammography can reduce breast cancer mortality. Frankl diagnosed 1,200 cancers in 35,000 women over a ten year period. Of these, 27% were occult (no positive physical findings). Less than 20% of these occult lesions had axillary node metastasis. Since prognosis so critically depends on the presence of nodal metastasis, it is not surprising that they measured a 50% lower mortality rate in the patients with occult lesions over ten years.[4]

In the past, there have been reservations about the usefulness of mammography, but these recent reports seem to indicate that screening is beneficial and it does improve prognosis to make the diagnosis before the tumor is palpable.

Legitimate doubts about radiation safety have led to controversy about the carcinogenic risk of mammography. This debate was given considerable attention in the national media, and there was a decline in the use of mammography in the 1970's. Whether low doses of radiation cause breast cancer is unknown, but if so, the incidence is so low that it has never been observed.

However, concern arose when it became clear from several sources that women exposed to high doses of radiation did indeed suffer an excess rate of breast cancer. These groups of women included two populations of sanatoria patients followed with chest fluoroscopy during treatment for tuberculosis and Japanese women exposed to radiation from atomic bombings at Hiroshima and Nagasaki. These groups were exposed to very high doses (between 150-300

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic Memorial Hospital, Jackson, MS.

RADS) and provide no data on the carcinogenic effect of radiation below one RAD. Nevertheless for purposes of developing mammographic guidelines, a very conservative approach (using worst-case calculations) has been used.

An estimate of 7.5 excess cancers per million women per year per RAD after a latent period of ten years has been calculated. This figure is extrapolated from the statistics gathered from the women discussed above and probably is an overstatement of risk.

A further moderating factor in risk calculation is age at exposure. The Japanese data indicate that women exposed at age 35 or older have a risk less than one-half that seen in younger women. Indeed, no increase in risk has been measured among the atomic bomb survivors exposed after the age of 20 to less than 100 RADS. Since most mammography is performed in older women, the risk estimate is reduced by one-half. Modern equipment results in a dose of about 0.3 RADS for a two view exam. A more realistic estimate of carcinogenic risk would be one excess cancer per million women examined per year after a latent period of ten years.

This hypothetical risk is best understood when compared to the natural incidence of breast cancer: 800 cases per million women per year at age 40, 1,800 cases per million women per year at age 50, and 2,500 cases per million women per year at age 65.[5]

As is true with every medical procedure, the benefits and risks of mammography should be carefully weighed. The hypothetical dangers of mammography seem small when compared with the potential benefits expected from it use.

The American Cancer Society has therefore recommended the following guidelines for the use of mammography.[6]

1. Every symptomatic woman over the age of 30 requires mammography to completely evaluate both breasts.
2. Women between the ages of 35-40 need a baseline examination. Women with a family history of breast cancer need earlier evaluation and more regular follow-up.
3. Women over the age of 50 should have an examination every year when feasible.
4. All women with a prior history of breast cancer require annual mammography.

Suite 101, 971 Lakeland Drive (39216)

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The President Speaking

Food for Thought

Ellis M. Moffitt, M.D.
Jackson, Mississippi

I consider it one of the highest honors that could be accorded to anyone to serve as president of our Mississippi State Medical Association. I will try to do justice to the honor.

I believe that medical practice finds itself in a competitive dilemma today. I want to devote this year's President's Page to a discussion of this dilemma and how we might best confront it.

Marketing is defined as a product or service that meets a need at a reasonable price. Then for what reasons should we as physicians market ourselves? To create better access for our patients. To extend hours so the hourly worker will not lose pay making a visit to his physicians. As a cost containment measure, i.e. less expensive to the patient in your office than in the emergency room. And to work with people who are down on their luck and cannot pay for all needed services at one time!

Another simple definition of marketing is: finding out what people need and then supplying it. What are some of the situations which might cause physicians to look more carefully at the economics of their practice? They are such things as: an increase in office expenses; a decrease in patient load (new patients as well as established patients); an inability of patient to pay at time of visit due to economic hardship; ambulatory care centers; and competition from HMOs, IPAs, PPOs, and joint ventures.

A question to ask yourself is: what business are you in now and what business do you wish to be in the future?

Let us consider some of the characters involved in today's health care scenario.

First, there's the patient. The patient today apparently is different from the one of yesterday, much as medicine is different. The patient today is looking for supermarket medicine — convenient as to time and place, central locations and satellites. In a recent survey in a large metropolitan area, 80% of the respondents stated that a doctor-patient relationship was not important. They wanted medical care at a time convenient to them and at a reasonable cost.

The second character in today's health care scenario is cost. Inflation alone accounts for 60% of the increase in health care costs. Thirty percent is due to increased demand and 10% due to population growth. Even in the face of recession, health care costs far exceeded the cost of living, even with a decrease in use rates. In the age group of 15-44 there were 25% less days of care in 1981

(Continued on page 155)

EDITORIALS

JOURNAL OF THE
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VOLUME XXV, Number 6

JUNE 1984

This Might Sting a Little

I've had it. I've really had it. Right up to here. I realize that I may well be stirring up a hornet's nest, as it is common knowledge that "Hell hath no fury like a woman scorned!"

They can buzz all they please, and even sting a little, but in the tradition of C. P. Crenshaw, by God, I'm going to say it!

The ladies, God bless 'em, are as we all know necessary to our lives, our practices and our families. But when in a prolonged session of the House of delegates, inured to tediousness when we pin our delegate's tag on, we are subjected to a parade (four — count 'em) of beautifully enunciated accounts of the programs and plans of our esteemed auxiliary, that last straw was added to the camel's back!

Please, please, ladies. Don't get me wrong. We deeply appreciate your efforts, your dedication. We *know* you can do it, for after all few of us would be where we are without you.

I herewith suggest that you save your elegant presentations for the auxiliary meetings, *not* the MSMA House of Delegates. I assure you that if such a suggestion is complied with, you will be deluged with a wave of appreciation from your spouses. After all, a man can only look down for so long without glancing about to meet long-suffering faces and blank expressions from his captive colleagues!

Now that my innate misogyny has surfaced, I pray that you will accept this suggestion in the heartfelt manner in which it is offered.

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

The President Speaking

(Continued from page 154)

than in 1975. In the age group of 45-64 there were 10% less days of care. In 1982 there were fewer days of care than in 1981. Why? New forms of care, ambulatory clinics, outpatient surgery clinics, and diagnostic clinics. There has been a decrease in daily and weekly visits to physician offices. There has been an increase in the number of organized medical groups and also an increase in HMO's, IPA's, PPO's and health care coalitions.

This brings us to the third character, physicians. By 1990 there is to be a surplus of physicians. New physicians find the cost of opening offices to be more expensive. They are finding salaried positions with prepaid plans an attractive alternative. There is fee for service (the traditional method of payment), price per case, price per person per year, and price per visit with discount.

Senator Dole, chairman of the Senate public health committee, has stated that 1982 was the year of the hospital and 1985 will be the year of the physician.

By 1990 the shortage of physicians will exist in only five specialties: emergency medicine will be 70% full; child psychiatry 45% full; psychiatry 80%; preventive medicine 75%; and rehabilitative medicine will be the specialty with the largest shortage. those near balance will be internal medicine, family practice, and pediatrics. There will be a surplus in all medical and surgical subspecialties.

By 1993 health care costs are expected to be a trillion dollars. This past year health care costs accounted for 11% of the GNP or $350 billion. Forty percent of the health care dollar goes to the hospital, 8% to nursing homes, 20% to physicians, 8% for drugs, and the balance for home health services, nurse midwives, etc.

It has been stated that we as physicians control 60-70% of the health care dollar. This fact has attracted much national attention and is the reason so much of the blame for rising health care costs has been placed on physicians. In a later president's page I will focus on mechanisms we can participate in as a medical society which will moderate the rise in health care costs.

★★★

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 117th Annual Session, May 15-19, 1985, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi, Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly, Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties. Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

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North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38665. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

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Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

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West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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4500 13th Street
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Oxford Lafayette County Hospital
P.O. Box 946
Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital
969 Lakeland Dr.
Jackson, MS 39216

Dr. Ellis Moffitt Begins Term as MSMA President

Dr. Ellis M. Moffitt of Jackson was inaugurated 1984-85 president of the MSMA during the 116th Annual Session, held recently in Biloxi. Dr. Moffitt succeeds Dr. Whitman B. Johnson of Clarksdale in the association's highest post.

The presidential inauguration concluded activities for the five-day meeting, which featured two sessions of the House of Delegates, two major scientific sessions, and numerous specialty society meetings. The week's agenda also included dozens of special events.

In addition to hearing addresses by Dr. Johnson and Dr. Frank Jirka, president of the AMA, some 150 MSMA delegates voted for nominees to fill association offices. As a result of the elections, Dr. Ralph Brock of McComb will serve as 1984-85 president-elect. His inauguration as president will come during the 117th Annual Session, May 15-19, 1985.

Dr. Moffitt, formerly chairman of the MSMA Board of Trustees, has a long record of service in professional organizations. He is past president of Central Medical Society, the Mississippi Society of Internal Medicine, and of the Southeastern Region of the American Association for Clinical Immunology and Allergy. He is charter president of the Jackson Academy of Medicine-Internal Medicine Society and former chief of the medical staff, Mississippi Baptist Medical Center. He has also served as clinical professor of medicine at the University of Mississippi School of Medicine.

Dr. Moffitt received his M.D. degree from Tulane University School of Medicine. After interning at the Mississippi Baptist Medical Center, he completed fellowships at the University of Virginia and the University of Michigan. He began his practice in Jackson in 1964, in association with the Mississippi Allergy Clinic.

The new MSMA president is noted for his concern about rising health care costs and for his support of efforts to slow the increase. He was a guiding force behind the formation of a coalition of Jackson area businessmen, insurance agents, and physicians which sought to help stabilize health care costs in Mississippi.

Dr. Moffitt has served as vice-chairman of the Board of Directors, Blue Cross & Blue Shield of Mississippi, Inc., and is a member of the Board of Directors of the Jackson Chamber of Commerce. He has served as chairman of the Board of Directors of the Mississippi Foundation for Medical Care and as a member of a special task force of the Governor's Office of Comprehensive Health Planning.

He is married to Dr. Nina Goss Moffitt, a psychiatrist. The MSMA "first family" includes two children, John and Ginny, both physicians.

384 Receive Degrees At UMC Commencement

Dr. R. Gerald Turner, Chancellor of the University of Mississippi, was the speaker for the 28th annual University of Mississippi Medical Center Commencement on Sunday, May 27.

Dr. Turner addressed the 384 degree candidates and their guests during the 4:00 p.m. ceremony in Jackson's city auditorium.

The UMC graduate total included 156 for the M.D.; 115 for the B.S. in nursing; and six for the M.S. in nursing. One student received the M.S. degree, two the master of combined sciences, and five the Ph.D.

Forty-two students received the D.M.D.; two the B.S. in cytotechnology; six the B.S. in medical record administration; nine the B.S. in medical technology; 12 the B.S. in nurse anesthesiology; 23 the B.S. in physical therapy; and five the B.S. in respiratory therapy.

Next Month in JOURNAL MSMA Complete Report, 116th Annual Session

PERSONALS

James Achord of UMC served on the planning committee for the National Institute of Arthritis, Diabetes and Digestive and Kidney Diseases in Bethesda, Maryland. He spoke to members of Singing River Medical Society in Pascagoula and was guest lecturer at Grenada County Hospital.

Orlando Andy of UMC presented a paper at the Southern Neurological Society meeting in New Orleans in March.

George Archer of Greenville was chosen "Doctor of the Year" by the State Association of Medical Assistants.

Blair Batson of UMC was an examiner for the American Board of Pediatrics in Charleston, South Carolina.

Ching J. Chen of UMC presented a paper at the University of Chicago Ophthalmology Alumni Meeting in March.

Felton Eugene Combest has associated with the Hollandale Clinic for the practice of pediatrics.

W. Wilson Defore, Jr. of Jackson was inducted into membership in the Society for Surgery of the Alimentary Tract at the society's annual meeting in New Orleans in May.

Alan Freeland of UMC spoke to members of the Columbia (South Carolina) Orthopedic Association recently and was on the faculty for a course sponsored by the American Society for Surgery of the Hand in Vail, Colorado.

Wilfred Gillis of UMC was a reviewer at the University of Vermont College of Medicine in Burlington.

Harper Hellems of UMC was a program participant at the Mississippi-Louisiana meeting of the American College of Physicians in Biloxi.

James Hughes of UMC was on the faculty for a course sponsored by the American Society for Surgery of the Hand in Vail, Colorado.

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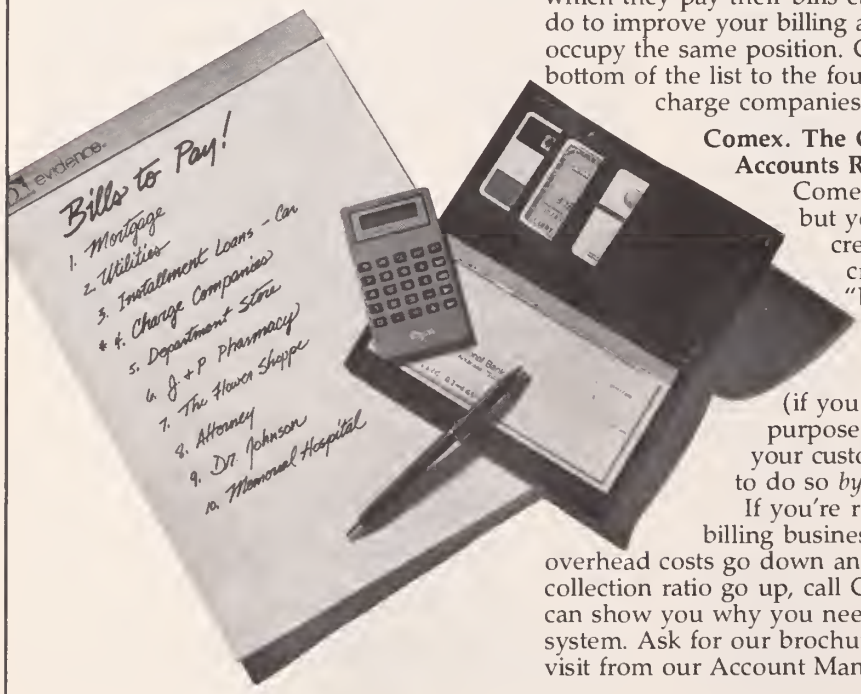

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A. Jerald Jackson of Hattiesburg has been named a fellow of the American College of Physicians.

Gary Jackson of Greenville announces the association of John Tanksley for the practice of orthopedic surgery.

John Kapp of UMC made presentations at the Hybridoma Technology Course in Durham, North Carolina, the Pediatric Oncology Group meeting in Clearwater, Florida, and the American Association of Neurological Surgeons annual meeting in San Francisco.

Herbert Langford of UMC presented a paper at the 24th annual conference on Cardiovascular Disease Epidemiology in Tampa, Florida and was guest speaker at the Veterans Administration Medical Center in Miami.

Patrick Lehan of UMC attended a Board of Governors meeting during the annual meeting of the American College of Cardiology in Dallas, Texas.

Eric E. Lindstrom of Laurel has been named a fellow of the American College of Surgeons.

Connie McCaa of UMC gave a research seminar at Mississippi State University in Starkville recently.

John M. McRae announces the relocation of his practice to Pine Grove Recovery Center, Alcohol and Drug Unit, 2255 Broadway Drive in Hattiesburg, in association with Doyle P. Smith.

Francis Morrison of UMC was in Oklahoma City, Oklahoma and New Orleans as quality control inspector for the Southwest Oncology Group.

Richard Nichols has associated with Gautier Diagnostic and Medical, P.A., for the practice of obstetrics and gynecology.

Howard Nichols of UMC was an examiner for the American Board of Pediatrics in Charleston, South Carolina.

K. Ramsay O'Neal of Hattiesburg has been named Mississippi State University's 1984 Alumnus of the Year.

Andrew Parent of UMC presented a paper at the Mississippi-Louisiana College of Physicians meeting.

George E. Patton, Jr. has associated with Internal Medical Group, P.A., 962 North Street in Jackson, for the practice of internal medicine.

William Pinkston of UMC moderated a panel during a meeting of the Society of Air Force Physicians in Vail, Colorado.

William B. Profilet, Jr. announces the opening of his office for the practice of obstetrics and gynecology at 801 1st Street in Cleveland.

Tom Randle of Oxford was speaker for a course for cancer patients sponsored by the American Cancer Society, Lafayette County Chapter.

Douglas W. Rouse of Hattiesburg made a presentation at the first combined meeting of the Mississippi and Alabama Orthopedic Societies at Point Clear, Alabama.

McWillie Robinson of Jackson was named recipient of the Distinguished Athletic Service Award presented by Millsaps College.

Sue Simmons of Maben announces the association of J. R. Anderson for general practice and obstetrics.

Robert Smith of UMC presented a paper at the annual meeting of the American Association of Neurological Surgeons in San Francisco.

E. Ross Smith announces the opening of his office for the practice of pediatrics in Philadelphia.

J. Tate Thigpen of UMC has been named 1984 Mississippi Crusade Chairman for the American Cancer Society.

Lamar Weems of UMC performed duties as president of the Southeastern Section of the American Urological Association at the society's meeting in Nashville, Tennessee.

DEATHS

Terrell, Kenneth D., Prentiss. Born Prentiss, MS, Sept. 13, 1914; M.D., Tulane University School of Medicine, New Orleans, 1939; interned St. Louis City Hospital, one year; member of South Mississippi Medical Society, Mississippi State Medical Association, and American Medical Association. Died May 17, 1984, age 79.

JOIN MPAC TODAY

NEW MEMBERS

Anfanger, Andrew S., Jackson. Born New York, NY, Sept. 8, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and residency in family practice, University Medical Center, 1980-83; elected by Central Medical Society.

Belenchia, Russell E., Union. Born Cleveland, MS, April 3, 1952; M.D., University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1982; interned one year, Lakeside Hospital, Kansas City, MO; elected by East Mississippi Medical Society.

Burke, William P., Jackson. Born Hattiesburg, MS, May 4, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; one year internship, Sloan-Kettering Cancer Hospital, New York, NY; one year residency, New York Hospital and Cornell Medical Center, New York, NY, 1981-82; elected by Central Medical Society.

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Burnett, W. David, Magee. Born Meridian, MS, Jan. 30, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and one year family practice residency, University Medical Center; elected by Central Medical Society.

Campbell, Annyce R., Jackson. Born Mound Bayou, MS, Oct. 11, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1978; family practice residency, University Medical Center, Jackson, MS, 1978-81; elected by Central Medical Society.

Dillon, Alva, Jr., McComb. Born Magnolia, MS, April 9, 1947; M.D., State University of New York at Buffalo, School of Medicine, Buffalo, NY, 1974; interned Letterman Army Medical Center, San Francisco, CA, one year; medicine residency, Temple University Hospital, Philadelphia, PA, 1977-79; elected by South Central Medical Society.

Fly, James Douglas, Jackson. Born McComb, MS, Feb. 7, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned St. John's Mercy Medical Center, St. Louis, MO, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1976-79; elected by Central Medical Society.

Garbin, Frank G., Ocean Springs. Born Biloxi, MS, March 10, 1929; M.D., University of Tennessee Center for Health Sciences, Memphis, 1955; one year internship, St. Joseph Hospital, Memphis; general surgery residency, San Juan City Hospital, San Juan, Puerto Rico, 1960-64; elected by Singing River Medical Society.

Green, Virginia A., Jackson. Born Montgomery, AL, Jan. 26, 1950; M.D., University of Alabama School of Medicine, Birmingham, 1975; interned one year, Children's Hospital, Cincinnati, OH; pediatric residency, same, 1976-78; neonatal fellowship, Duke University, Durham, NC, 1978-80; elected by Central Medical Society.

Hsu, Patrick S., Greenville. Born Shanghai, China, July 23, 1952; M.D., University of Toronto, Toronto, Ontario, Canada, 1977; interned and general medicine residency, Toronto East General Hospital, 1977-79; ob-gyn residency, University of Western Ontario, London, Ontario, Canada, 1978-80; ob-gyn residency, Univ. Toronto, Toronto, Ontario, Canada, 1980-82; elected by Delta Medical Society.

Hubbs, David R., Brookhaven. Born Baton Rouge, LA, Feb. 15, 1952; M.D., Louisiana State Universi-

ty School of Medicine, New Orleans, 1978; interned one year, City of Memphis Hospitals, Memphis, TN; ob-gyn residency, University of Tennessee, Memphis, 1979-82; elected by South Central Medical Society.

Hunt, Marion Glenn. Born Jackson, MS, Sept. 24, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned one year, University Medical Center; elected by Central Medical Society.

Locke, William R., Starkville. Born Starkville, MS, Oct. 3, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and ob-gyn residency, University Medical Center, 1979-83; elected by Prairie Medical Society.

Mason, Phyllis E., Corinth. Born Murphy, NC, Jan. 7, 1942; M.D., University of Tennessee College of Medicine, Memphis, 1967; interned and radiology residency University of Tennessee, Memphis, 1968-71; elected by Northeast Mississippi Medical Society.

O'Donnell, James A., II, Laurel. Born Memphis, TN, Dec. 28, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and pediatric residency, University Medical Center, 1978-81; elected by South Mississippi Medical Society.

Reynolds, George M., Jr., Jackson. Born Jackson, MS, Feb. 5, 1951; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1977; interned, Vanderbilt University, Nashville, and Cleveland Metro General Hospital, Cleveland, OH, one year; medicine residency, Cleveland Metro General, 1978-81; cardiology fellowship, same, 1981-83; elected by Central Medical Society.

Robinson, William T., Ocean Springs. Born Laurel, MS, April 12, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned U.S. Naval Hospital, Chelsea, MA, one year; general surgery residency, University Medical Center, Jackson, MS, 1967-72; elected by Singing River Medical Society.

Sanders, Thomas J., Long Beach. Born Navasota, TX, July 21, 1955; M.D., University of Texas Medical Branch, Galveston, 1981; interned, same, one year; elected by Coast Counties Medical Society.

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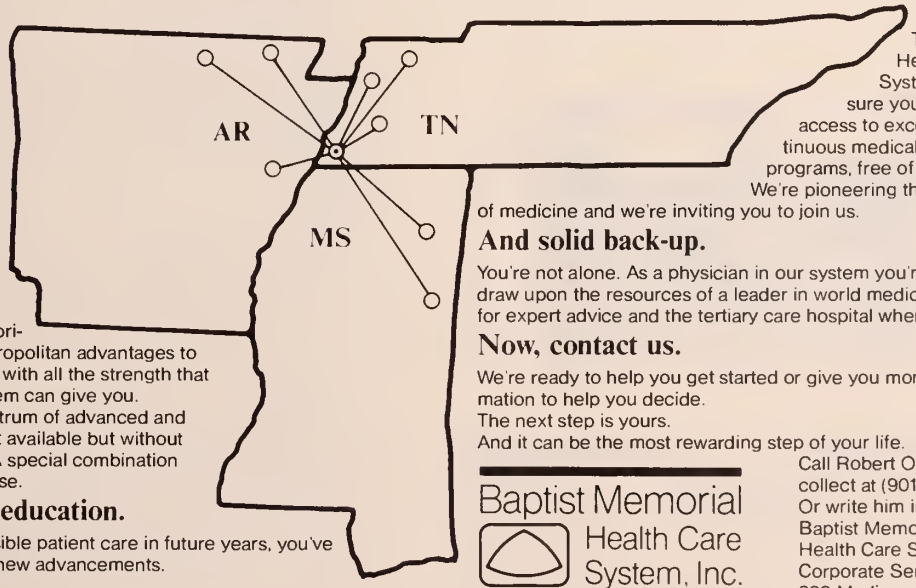

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NEW MEMBERS / Continued

TANKSLEY, JOHN A., Tupelo, MS. Born Ironton, OH, Jan. 15, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and orthopedic surgery residency, UMC, Jackson, MS, 1978-82; pediatric orthopedic fellowship, Scottish Rite Hospital, Atlanta, GA, 1982-83; elected by Northeast Mississippi Medical Society.

THOMAS, DAVID R., Jackson. Born Jackson, MS, April 26, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned and medicine residency, University Medical Center, 1971-75; elected by Central Medical Society.

VANLANDINGHAM, PAUL D., Jackson. Born Jackson, MS, May 29, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, University Medical Center, 1980-83; elected by Central Medical Society.

WADE, JOHN D., Kosciusko. Born Hattiesburg, MS, Dec. 26, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and radiology residency, University Medical Center, 1977-81; elected by North Central Medical Society.

WEBSTER, STEVAN A., Long Beach. Born Muncie, IN, May 2, 1951; M.D., Indiana University School of Medicine, Indianapolis, 1977; interned and medicine residency, Tulane University Affiliated Hospitals, New Orleans, 1977-70; fellowship in cardiology, Texas Health Science Center, San Antonio, 1980-82; elected by Coast Counties Medical Society.

WINDHAM, ALFRED G., Vicksburg. Born Vicksburg, MS, Nov. 3, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned UMC, Jackson, MS, one year; otolaryngology residency, Duke University Medical Center, Durham, NC, 1981-84; elected by West Mississippi Medical Society.

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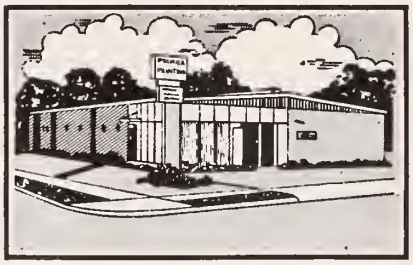

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Medico-Legal Brief

HHS "Squeal Rule" Not Authorized by Statute

The "squeal rule," which required all federally funded family planning clinics to notify parents after prescribing contraceptives to minors was not authorized by statute, a federal appellate court in New York ruled.

In 1981, amendments to the Public Health Service Act stated that to the extent practical, recipients of federal funds should encourage family participation in family planning activities. In issuing the rule requiring notification of parents within ten days from the time the contraceptives or services were provided, the Secretary of Health and Human Services said that the rule balanced the congressional policy of encouraging family involvement with the policy of preventing teenage pregnancies. A trial court permanently enjoined the implementation of the rule.

Affirming the decision, the court said the 1981 amendments did not authorize the mandatory notification rule. Congress meant to encourage parental involvement by having minors involve their parents. It was not intended that the family planning groups directly involve parents or guardians, the court said. — *State of New York v. Heckler*, 719 F.2d 1191 (C.A.2, N.Y., Oct. 7, 1983).

POSTGRADUATE CALENDAR

FUTURE CALENDAR

Aug. 18
Ophthalmology Update 1984
Holiday Inn Downtown, Jackson

Sept. 6
Bulimia and Anorexia Nervosa
Holiday Inn North, Jackson

Oct. 4-5
Family Practice Update
Jackson

Oct. 26-27
Annual Pediatric Meeting
University Medical Center, Jackson

For registration information and a brochure, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505. Phone (601) 987-4566.

NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

Next Month in JOURNAL MSMA

- Complete Report, 116th Annual Session
- "Nuclear Waste Storage in Mississippi — An Issue of Health"
- "Evaluation of an Abnormal Pap Smear"

PLACEMENT SERVICE

Situations Wanted

Native Mississippian completing pediatric residency in July 1984 seeks location in state. Contact Tom Ireland, M.D., 3516 Casawoods Lane, Clarkston, GA 30021; (404) 296-2940.

Board Certified internal medicine physician seeks location for small rural practice. M.D. from Johns Hopkins University. Contact Edwin B. Struve, M.D., 29 Dellwood Avenue, Chatham, NJ 07928.

Anesthesiologist seeks practice location. Box A, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

Board certified head and neck surgeon now finishing facial plastic surgery fellowship. Desire opportunity or association in which to develop facial plastic and reconstructive surgery practice. Contact Donn R. Chatham, M.D., 1516 South 20th St., Birmingham, AL 35205; (205) 933-8799 or 871-0429.

PLACEMENT SERVICE / Continued

General surgeon seeks relocation in Mississippi. Box S, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

Otolaryngologist currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

Pathologist seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

Board certified family practitioner seeks location in Jackson or Greenville area with established group beginning August 1, 1984. Contact Hernando C. Payne, M.D., 1557-A Eglin Way, Washington, DC 20336.

Physicians Wanted

Family Practitioners. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

Family Physician. Ideal practice opportunity in thriving central Mississippi community of 5,000. Surrounding trade area has 25,000 population base. Excellent opportunity for OB practice if desired. Situated within one hour's drive of Jackson. Reply to Box B, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

Family Physician wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

Family Practitioner for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

Fully Equipped ob-gyn clinic available for immediate occupancy. Trade area of approximately 50,000 persons; modern hospital; no other obstetricians in immediate area. Contact Mr. James Townsend, Administrator, Bolivar County Hospital, Cleveland, MS 38732, or call (601) 846-2550.

Community seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

Family Practitioner wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

General Surgeon wanted in Union, Mississippi. Seven referring GPs; attractive guarantee; office space furnished. Contact Margaret Muse or John Bradshaw, Laird Hospital, Union, MS 39365; (601) 774-8214.

Family practitioner wanted for west central Mississippi town in Hinds County, population 1,000 — draws trade from four counties; less than 30 miles to hospitals; good highways. Facilities can be provided if desired. Call (601) 885-8718 or write to Mayor James Keith, P.O. Drawer K, Utica, MS 39175.

Community seeks general surgeon. Contact Mr. William E. Rutledge, Administrator, Tishomingo County Hospital, Iuka, MS 38852.

CLASSIFIED

Consulting Physicians. Board eligible orthopedic and psychiatric consultants needed 25-30 hours per week for evaluation of Social Security disability claims. Positions available immediately. For additional information, please call Deborah Warriner, Medical Staff Coordinator, Disability Determination Services, (601) 923-2153.

For Sale or Lease. Fully equipped clinic located at Clarksdale. Central heat and air; x-ray and lab equipment included; owner financing available. Call 624-6239 (Clarksdale) or 981-6678 (Jackson) for more information.

53-year-old ABFP, on Mississippi Gulf Coast, needs board certified/qualified family practitioner as associate or partner. Financial arrangements negotiable. Please send information to Box K c/o Journal MSMA.

Virginia Heart Institute provides on-site consultation for administrators interested in the development of ambulatory facilities including outpatient cardiac catheterization. If interested, write Patricia Ferree at Virginia Heart Institute, 205 N. Hamilton St., Richmond, VA 23221.

Physicians interested in practice opportunities in the Southeast, please contact: Director, Physician Recruitment, Regional Health Services, Inc., P.O. Box 2345, Anniston, AL 36202; (205) 236-2907.

Wanted — Two Family Practitioners to join established family practice that wishes to expand to give more flexibility and support. Up-to-date but relaxed practice in busy clinic in the heart of the Mississippi Delta. This is a small town of approximately 3,000 with the hospital serving a population of 15,000. Newly refurbished, the hospital includes 25 Acute Care beds, 7 ECF and a 60 bed Nursing Home. This is a small community with excellent hunting and fishing areas and relaxed Southern living. Enjoy rural living with a short drive to major urban areas. Write: Administrator, Humphreys County Memorial Hospital, P. O. Box 510, Belzoni, MS 39038. Telephone: (601) 247-3831.

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IN CONCLUSION

Prospective payment system is the issue that gave rise to the largest number - 25 - of resolutions in the handbook for the annual meeting of the AMA House of Delegates. Several of the resolutions urged the AMA to lead a campaign to repeal Medicare's use of DRGs. Others called for studies of the impact of DRGs on quality of care. Ten protested the HCFA's requirement that the attending physician sign a statement verifying the accuracy of diagnoses and procedures. Delegates will consider a total of 123 resolutions at this month's meeting.

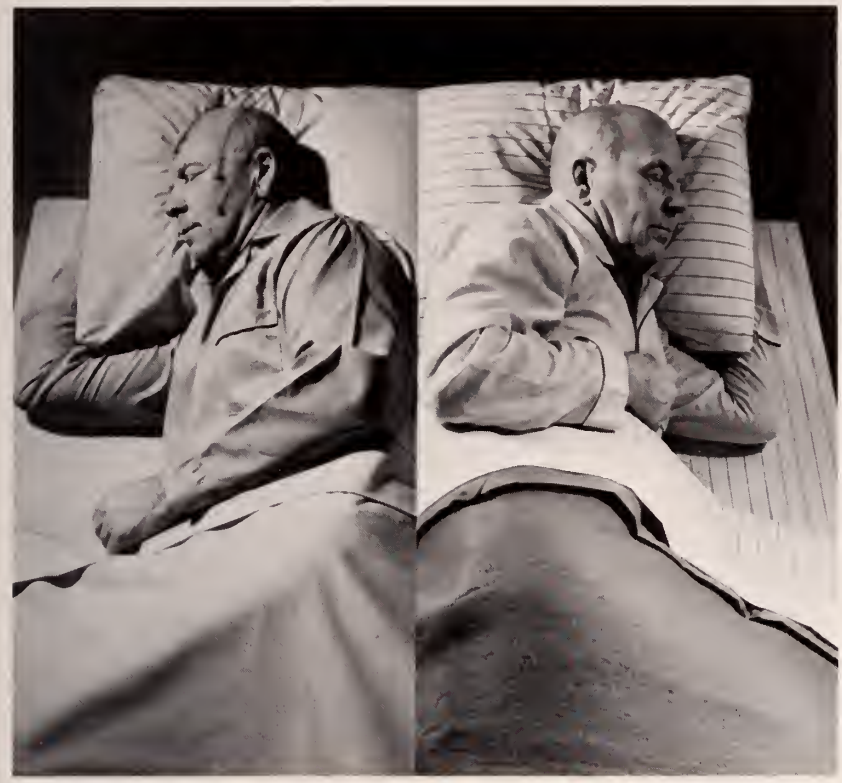
Conflicting positions on the insanity plea are presented in the June 8 issue of JAMA. The AMA's call for abolition of the special defense of insanity is answered by the American Bar Association and the American Psychiatric Association. Both the ABA and the APA favor reform of the insanity defense rather than abolition. The AMA recommends abolishing the plea and substituting a number of provisions aimed at protecting society from mentally ill patients known to be violent.

Most sun worshipers refuse to use sunscreens even when carefully informed of the hazards of sun exposure and benefits that sunscreens provide, according to an article in the June Archives of Dermatology. Researchers surveyed 489 patients and found that only 41% used sunscreens, typically in the belief they would promote tanning. In a follow-up evaluation, after supplying informational pamphlets and samples of sunscreens, the researchers found that virtually all demonstrated better knowledge, but virtually none demonstrated improved use of sunscreens.

Women constitute a growing proportion of the medical profession, and that proportion will continue to increase because more women are entering the profession than ever before. From 1970 to 1981, the percentage of female physicians increased from 7.7% to 12.2%. Nearly 30% of today's medical students are women. Career choice differences between female and male physicians can be noted in type of specialty, type of practice, and hours of work each week, according to the AMA's SMS Report of March 1984.

Board of Directors of the American Academy of Family Physicians adopted a new policy statement affirming support for freedom of choice for patients and physicians. The statement declares, "...certain forms of health care delivery may limit patient access to a specified physician or physicians in order for the patient to participate in that health care plan. However, despite the existence of such plans, the AAFP continues to support freedom of choice for both physicians and patients in selecting any ethical form of health care delivery."

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF



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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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July 1984

JOURNAL of the MISSISSIPPI State Medical Association

Carotid-Subclavian Bypass for Subclavian Steal Syndrome

Evaluation of an Abnormal Pap Smear

Highlights, 116th Annual Session

Special Report: Nuclear Waste Storage in Mississippi — An Issue of Health

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July 1984, Volume XXV, Number 7

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NEWSLETTER

July 1984

Dear Doctor:

This month MSMA will distribute to Mississippi radio and television stations a series of public service announcements concerning the hazards of storage of high level nuclear wastes in Mississippi's salt domes. The information campaign also includes a brochure for distribution to the public. All of the materials urge citizens to contact members of Congress and federal agencies to express opposition to the proposed nuclear waste storage sites in Mississippi.

> Mississippi's salt domes in Perry County are among nine sites across the country (in six states) which are under consideration by the Department of Energy for nuclear waste repositories. Next month that list will be narrowed, as the process of reaching a final decision continues.
>
> The MSMA House of Delegates adopted a resolution at the 116th Annual Session which officially stated the association's position that "the development of a facility for the storage of high level nuclear waste in Mississippi's salt domes represents an unacceptable hazard to the health of the state."
>
> This issue of Journal MSMA includes a special article on the subject by Dr. Don LaGrone of Biloxi.

Medical Assurance Company of Mississippi (MACM) presented the third annual Robert S. Caldwell Memorial Award to Sam J. Denney, Jr., M.D., a third-year resident in pediatrics at UMC. Dr. Denney begins private practice this month in association with Children's Clinic of Jackson. An ad hoc faculty committee selects the recipient for demonstration of in-training excellence in medical practice, patient relations, and documentation of patient care. The award is named for the late general surgeon from Tupelo, who was president-elect of the MSMA at the time of his death. Dr. Caldwell was also a member and secretary of the Board of Directors of MACM (then called Mississippi Medical Fraternal and Educational Society/MMFES).

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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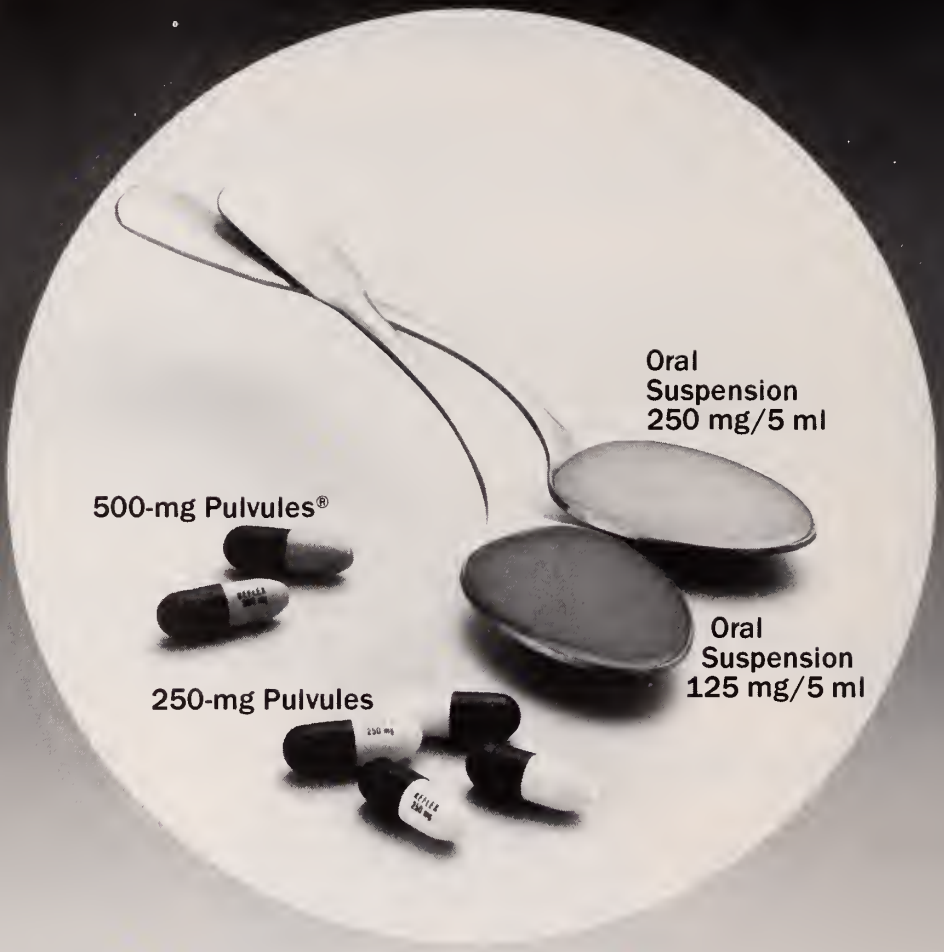

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DATELINE

MFMC Advances In PRO Bidding

Jackson, MS - Mississippi Foundation for Medical Care was among bidders from 32 states which advance to round two for contracting as a Professional Review Organization. Bids from 15 states have been rejected. The PRO program is the successor to PSRO, and HCFA has announced its intent to name current Medicare intermediaries as PROs in states where bids are unsuccessful.

AMA Opposes New Federal Agency

Chicago, IL - The AMA Board of Trustees opposed bills in the Congress that would create a medical technology assessment agency to determine whether new developments should be reimbursable under federal health programs. The Council on Legislation told the Board that "these bills are unnecessary in light of existing government and private technology assessment activities."

Nurse-Midwives In Wrongful Death Suit

Seattle, WA - A $725,000 settlement was reported in a wrongful death suit involving nurse-midwives at a birthing clinic. The case involved the death of a 29-year-old woman and her child, from eclampsia during labor. The suit charged the midwives with violation of state statutes establishing the duty to consult with a physician whenever significant deviations from normal occur.

Reliability of Breath Alcohol Test

Dallas, TX - A high level of accuracy was reported in a study to determine reliability of hand-held breath alcohol analyzers. The report, in Annals of Emergency Medicine, noted, "a rapid and dependable method of measuring blood alcohol levels helps in the evaluation and management of patients with altered mental status, which often is attributed erroneously to alcohol."

Plan for 1985 Annual Session

Jackson, MS - This issue of Journal MSMA includes a complete review of the recent 116th Annual Session. Later this summer the planning group will meet in Jackson to begin preparations for next year's meeting, May 15-19, at the Royal d'Iberville Hotel in Biloxi. MSMA members and spouses are urged to mark calendars now for the 117th Annual Session.

Roche salutes
the history of Mississippi medicine

SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.[1]

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An ero of specialists, chop 5, in Lee RV, Eimerl S *et al. The Physician* New York, Life Science Library, Time Inc , 1967, pp 107-109

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When the history reveals mixed depression and anxiety...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,[1] Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl/Roche), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs which has been associated with tardive dyskinesia.

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p 316. **2.** Feighner JP *et al: Psychopharmacology 61*:217-229, Mar 1979 **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® Tablets Ⓜ Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 50

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NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

References:

1. Stone PH, Turi ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PRDCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PRDCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure. Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PRDCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension. Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PRDCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

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ORIGINAL PAPERS

Carotid-Subclavian Bypass for Subclavian Steal Syndrome

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In 1961, Reivich, et al[1] described reversal of blood flow through the vertebral arteries and the effects on cerebral circulation. Although reversed vertebral artery blood flow due to proximal subclavian occlusion was proven by Contorni in 1960,[2] Reivich was the first to correlate the angiographic findings with intraoperative flow studies and to correct the neurologic symptoms with subclavian endarterectomy. It remained for the editors of the *New England Journal of Medicine* to attach the label "Subclavian Steal Syndrome."[3]

The mechanics of subclavian steal are simply stated (see Figure 1). There is usually total obstruction of the proximal subclavian artery, typically due to arteriosclerosis. At a point where a pressure gradient of greater than 20-40 Torr exists between the vertebral-basilar junction and the vertebral-subclavian junction, the steal effect occurs. The neurological effects are due to diminished perfusion of the portion of the brain nourished by the basilar artery.

Many surgical procedures have been recommended for the correction of subclavian steal syndrome. Perhaps the first was reported in 1866 by Smythe.[4] In this report, a patient with post-traumatic subclavian aneurysm presented with recurrent syncope. It was postulated by Smythe that a siphon effect could occur through the vertebral system, and he ligated the vertebral artery with complete resolution of the patient's symptoms. With the resurgence of interest in subclavian steal syndrome in 1961, vertebral artery ligation has again been recommended. The initial operation performed by Reivich, et al, was subclavian endarterectomy.[1] Various other procedures have been recommended such as aorto-subclavian bypass, subclavian-subclavian bypass and axillo-axillary bypass.

In 1962 North, et al[5] reported nine patients with subclavian steal syndrome and suggested the term "brachial-basilar insufficiency syndrome." In four of their nine patients, carotid-subclavian bypass was performed. The first procedure was accomplished on July 28, 1961, and is apparently the first carotid-subclavian bypass reported, and certainly the first reported for the treatment of this syndrome.

Since 1967, the authors have used carotid-subclavian bypass exclusively in the treatment of the syndrome, except in those patients with subclavian steal secondary to total occlusion of the innominate artery (see Figure 2). In this instance, ascending aorta-to-right subclavian artery bypass has been utilized. We feel that this is the definitive procedure for subclavian steal syndrome, and it is the purpose of this report to evaluate a series of 39 patients operated upon in the past 16 years.

In this consecutive series of 39 patients, the average age was 62, with a range of 44 to 85 years. There

From the Department of Surgery, University Medical Center, Jackson, MI (Dr. Dalton).

were 22 males and 17 females. The left side was affected 73% of the time. There were six patients (15%) that required concomitant ipsilateral carotid endarterectomy. The presenting symptoms were commonly vertigo or syncope, one or both of which was present in 84% of these patients. Twenty-eight percent complained of claudication of the affected extremity with exercise.

Diseases commonly associated with atherosclerotic conditions were a frequent finding in this series (see Table 1). There was a high incidence of heavy cigarette smoking and 70% had demonstrable chronic obstructive lung disease. There was associated coronary disease in 51%, and 59% had other peripheral vascular disease. Of the series, 49% had hypertension under medical treatment, and 5% had diabetes mellitus.

Physical findings consisted of absent or diminished radial pulse, with blood pressure differential greater than 20 Torr in 84%, with blanching of the extremity in 24%. The vast majority of the patients had a demonstrable bruit in the subclavian area on the affected side.

The diagnosis was confirmed in all patients by arch aortography as well as selective carotid and subclavian arteriograms. The typical patient demonstrated total or near total occlusion of the subclavian artery due to arteriosclerosis at its origin with delayed retrograde filling through the ipsilateral vertebral artery on the films obtained at two to three seconds post-injection (see Figures 3 and 4). Although there are numerous other causes for subclavian steal syndrome, all the patients in this series had the syndrome due to arteriosclerotic occlusion of the affected subclavian artery.

Surgical Treatment

We believe that the primary treatment of subclavian steal syndrome is carotid-subclavian bypass. We have progressed through subclavian endarterectomy and other bypass procedures such as aorto-subclavian bypass with the impression that carotid-subclavian bypass is a superior procedure from many standpoints. Our technique employs general anesthesia with minimal muscle relaxation. A supraclavicular incision is made and the clavicular head of the sternocleidomastoid is divided. The sternal head of the sternocleidomastoid is preserved for its cosmetic as well as its functional value. The anterior scalene muscle is divided and the subclavian artery exposed. The left common carotid artery is then exposed and the patient is heparinized after preclotting a 6 or 8 mm dacron velour graft. The carotid is clamped with angled vascular clamps and the graft is sutured end-to-side to the carotid artery without using an internal shunt. It has been demonstrated by

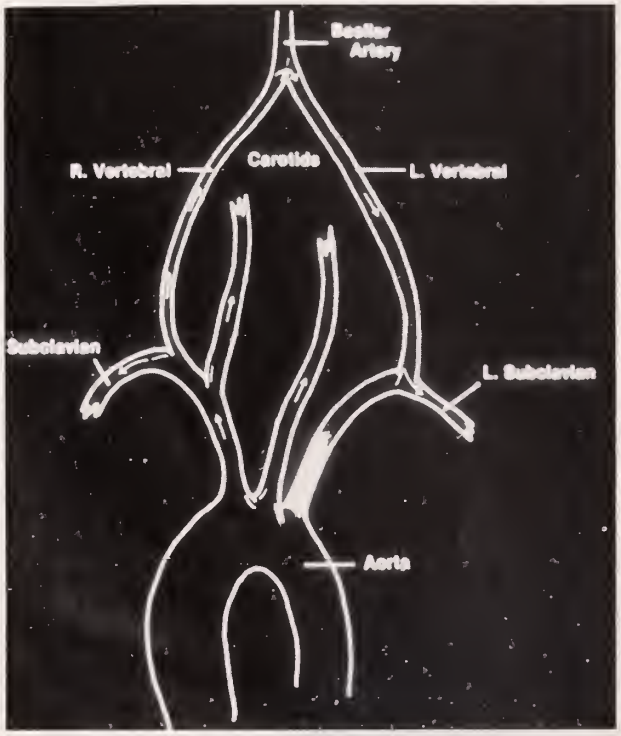

Figure 1. Mechanics of left subclavian steal.

Figure 2. Right and left carotid-subclavian bypasses.

Figure 3. Angiographic study showing total occlusion of left subclavian and retrograde filling of left vertebral artery.

Figure 4. Angiographic study showing late filling of the left subclavian artery via retrograde perfusion from the left vertebral artery, three seconds post-injection.

Thompson et al[6] that collateral flow through the external carotid is more than adequate for this brief period the common carotid is clamped. Thus, an internal shunt is not only cumbersome but also unnecessary. The subclavian artery is then clamped and end-to-side anastomosis of the beveled graft to the subclavian artery is accomplished.

Results

As shown in Table 2, there has been no mortality, and the morbidity has been extremely low and involves two of the 39 patients (5%). One lymphatic fistula requiring surgical correction occurred, and one patient suffered a cardiac arrest on the first postoperative day due to an arrhythmia. She required cardiopulmonary resuscitation and tracheostomy, but recovered fully without neurological problems and survived for ten years following the procedure. There have been no transient or permanent neurological deficits and there have been no infections. This group of 39 patients has been followed

TABLE 1
ASSOCIATED DISEASES

Chronic Obstructive Lung Disease	70%
Coronary Disease	51%
Hypertension	49%
Diabetes Mellitus	5%
Other Peripheral Vascular Disease	59%

TABLE 2
COMPLICATIONS

1. Operative Mortality	0
2. Operative Morbidity	
1. Lymph Fistula	1
2. Arrhythmia, cardiac arrest, post-op tracheostomy (survived 10 years)	1
3. Neurological deficits (transient or permanent)	0
4. Infection	0

for three months to 15 years, with an average follow-up of 7.5 years. Seven patients were lost to follow-up, and six patients are deceased, with an average survival of seven years.

Discussion

Alternative operative procedures have been recommended and have by and large been abandoned except for very selected groups of patients. The morbidity and mortality of subclavian endarterectomy is unacceptably high as compared to carotid-subclavian bypass.[6] This is presumably due to the requirement of either a thoracotomy or median sternotomy for the procedure, as well as the intrinsic friability of the subclavian artery. An aorto-subclavian bypass is recommended only for innominate artery occlusion, and is not recommended for subclavian occlusion, as it requires more operative exposure and the results have not been proven superior to that of carotid-subclavian bypass.

Subclavian-subclavian bypass and/or axillo-axillary bypass has been recommended and, although it can be performed under local anesthesia, should be avoided insofar as possible. Inherent problems with this procedure include the fact that the prone position is rendered potentially thrombogenic, the patient must avoid tight collars and future tracheostomy would constitute a major problem. In addition, median nerve palsy and skin erosion along the subcutaneous tunnel, particularly in the elderly, thin patient have been reported.[6] Most importantly, our series indicates a high correlation between this disease and coronary atherosclerotic heart disease. Since a large portion of these patients may well come to coronary bypass surgery, median sternotomy would constitute a major problem in the management of such a patient.

Summary

The diagnosis of subclavian steal syndrome can usually be made by history and physical examination, and is readily confirmed by selective arteriography. Carotid-subclavian bypass is the preferred treatment for this syndrome for a number of reasons, most important of which is the fact that it is expedient and well tolerated, as thoracotomy and/or median sternotomy is avoided: it is essentially "surface surgery." The use of a temporary internal shunt is avoided, the morbidity and mortality is very low, and in this series, there was no incidence of Horner's syndrome, false aneurysm, neurological deficits or post-operative infection. ★★★

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Evaluation of an Abnormal Pap Smear

G. RODNEY MEEKS, M.D., Series Coordinator
CHARLES E. SAMPSON, JR., M.D., Moderator
Jackson, Mississippi

Dr. Sampson: A 25-year-old G2, P2 black woman was referred to the Gynecology Department at University Medical Center for evaluation of an abnormal pap smear. Her last menstrual period occurred three weeks before evaluation. An earlier cervix pap smear showed mild to moderate dysplasia. The patient was otherwise asymptomatic. What are common features in women with abnormal pap smears?

Dr. Evans: The etiology of dysplasia and carcinoma in situ of the cervix is unknown. It seems, however, that sexual intercourse must have occurred for a woman to develop invasive squamous cancer. Indeed, the association of cervical cancer with indigent populations and sexual factors has been identified in numerous epidemiologic surveys. Recent studies have incriminated early age at first coitus and related factors such as early marriage, high parity, divorce, age at first pregnancy, and multiple sexual partners as predisposing features. The rarity of cervical cancer among celibate women implies that this malignancy is sexually transmitted. On the other hand adenocarcinoma of the cervix, which accounts for 5% of cervical neoplasms, can arise in virgins.

Dr. Flynt: The occurrence has been linked to herpes virus type 2 infection. Sperm have also been implicated; however, smegma and circumcision are not longer considered important factors. The concept of a high risk male has also evolved. For example, a woman who is married to a man previously married to a woman with cervix cancer or who has penile cancer has a higher than expected incidence of cervix cancer.

Dr. Howe: These features do indeed define high risk groups. However, individual women for the most part are asymptomatic and have unremarkable pelvic exams. Therefore, the only way to screen women for cervical dysplasia is to perform pap smears on all women.

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS.

Panelists: S. R. Evans, Jr., M.D., Greenwood; Joel Flynt, M.D., Hattiesburg; and Michael Howe, M.D., Starkville.

Dr. Sampson: Pap smears are reported in different ways depending upon the community in which one lives, and this can be a very confusing problem. What method of pap smear reporting is utilized in your community?

Dr. Howe: Our pathologists classify pap smears numerically and give a narrative description. A Class O smear is unsatisfactory, a Class I smear is negative, a Class II smear represents mild to moderate dysplasia, and Class III represents severe dysplasia to carcinoma in situ. A Class IV smear indicates a suspicion of invasive carcinoma.

Dr. Flynt: Our pathologists place more emphasis on describing the smear than on a numerical classification and, I believe, would like to eliminate the numerical classification.

Dr. Evans: Probably the most important point is that one needs to talk to the pathologist and understand exactly what his report means.

Dr. Sampson: If a patient has elective gynecologic surgery, when should she have a pap smear?

Dr. Flynt: I always get a reliable pap smear before elective surgery, especially tubal ligation. One would not want to find several months later that the patient has an abnormal pap smear which requires colposcopy and possibly further surgery.

Dr. Howe: If I have performed a pap smear within a year and the report was normal, then I would not repeat it. I would proceed with surgery and repeat the smear approximately one year after the last one.

Dr. Evans: I would have no problem relying on a pap smear which I did six to nine months prior to surgery. If I do not know the patient well or if the pap smear was done at a place unfamiliar to me, I would repeat the smear prior to surgery.

Dr. Sampson: Had you never seen the patient, would you perform a pap smear prior to surgery?

Dr. Howe: Absolutely!

Dr. Sampson: The patient had undergone elective bilateral tubal ligation one year ago. The cervix was hypertrophic, and old obstetrical lacerations were present at 3 and 9 o'clock. The remainder of the history and physical examination were not remarkable. In summary, you are confronted with an asymptomatic 25-year-old woman with two children who has had a tubal ligation. She has been referred to you for evaluation of a pap smear showing moderate dysplasia of the cervix (see Figure 1). What should one do now?

Dr. Flynt: I would do my own pap smear if the referral smear had been interpreted elsewhere. Since the referral pap smear showed moderate dysplasia, I would proceed immediately with colposcopy.

Dr. Sampson: Do you have a problem performing the pap smear at the time of colposcopy?

Dr. Evans: I have not had any major problems. However, I always do colposcopy first because the pap smear may cause bleeding and obscure the cellular changes.

Dr. Howe: I would do a diagnostic cone, anticipating that the patient will require hysterectomy. In those patients who desire more children, I refer them to someone who does a large volume of colposcopy since I do not use colposcopy in my practice. I might add that one has to perform a moderate number of colposcopies to be proficient, and I do not feel I could do enough to maintain a high degree of skill.

Dr. Sampson: Whom do you colposcope?

Dr. Evans: Basically, anyone with an abnormal pap smear for any reason is colposcoped. Some would argue that this is not necessary for mild dysplasia.

Dr. Sampson: A pap smear performed on the patient's first visit to UMC was interpreted as moderate dysplasia. Colposcopic examination of the cervix revealed areas of white epithelium at 7 and 9 o'clock. The entire squamocolumnar junction was visualized as was the full extent of both white lesions. A biopsy was taken from each white lesion, and histological examination revealed moderate to severe dysplasia. An endocervical curettage (ECC) was not done. Should ECC's be done?

Dr. Evans: If I cannot see the upper extent of the lesion I proceed to cone, irrespective of what the ECC might show.

Dr. Flynt: I do ECC's on all patients because an occasional lesion high in the endocervical canal may be missed by colposcopy alone. In addition, 5% of cervix cancers are adenocarcinomas, and these are likely to arise high in the endocervical canal, not at the squamocolumnar junction.

Dr. Sampson: What are the treatment options in this patient?

Dr. Flynt: The options are hysterectomy, conization, and cryocautery.

Dr. Howe: The options I present depend on the individual. For instance, I would probably recommend hysterectomy if the patient is unreliable and might not return for regular follow-ups. I would recommend that the patient have a hysterectomy, although one might treat her with a cone or with cryocautery.

Dr. Evans: I would recommend a hysterectomy, since further child-bearing is no longer a consideration.

Dr. Sampson: Would the management be altered if the patient had not undergone a previous tubal ligation?

Dr. Evans: If she had not had a previous tubal ligation and wanted more children, I would treat her with cryocautery. If she did not want more children but did not want a hysterectomy under any circumstances, then I would perform a cone. Since this patient had a prior tubal ligation, I would recommend hysterectomy.

Dr. Sampson: Do you prefer cryosurgery to conization if the patient desires preservation of her reproductive capacity?

Dr. Evans: Yes, assuming that the entire extent of her lesion can be seen and evaluated with the colposcope. If the entire lesion is not seen, then one must perform a cone biopsy.

Dr. Howe: One must remember that infertility may result if too much of the mucus-secreting glands are lost. Furthermore, incompetent cervix may occur or the cervix may fail to dilate during labor as the result of a cone.

Dr. Sampson: She was admitted to the hospital for hysterectomy. Admission laboratory data were within normal limits. Is vaginal or abdominal hysterectomy better:

Dr. Flynt: Posthysterectomy recurrences are more likely to follow abdominal rather than vaginal hysterectomy. Staining the cervix with Lugol's solu-

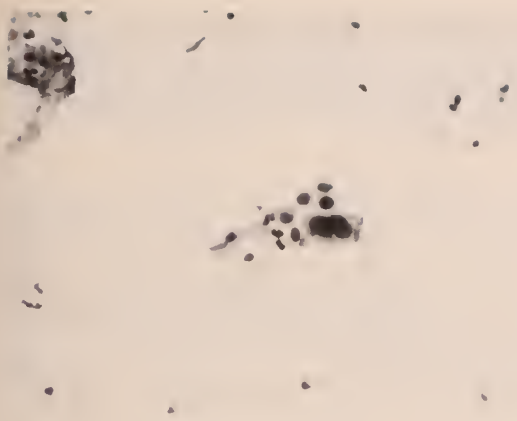

Figure 1. Pap smear. Moderate dysplasia. The nuclei are large and hyperchromatic, and chromatin is dense. The nucleus to cytoplasm ratio is large.

Figure 2. Cervix biospy. Moderate dysplasia. Immature cells are seen in one-half the total epithelial thickness. The vacuolated appearance of the cells in the superficial portion of the epithelial surface represents koilocytosis.

tion allows for more certain identification and removal of the entire lesion. Some physicians even do colposcopy in the OR just prior to the hysterectomy.

Dr. Sampson: On the following day the patient underwent vaginal hysterectomy with no difficulty and was discharged on the fourth postoperative day. Histological examination of the specimen showed foci of moderate and severe dysplasia (see Figure 2). All surgical margins were free of dysplasia.

Let us also presume that severe dysplasia was present at the margin of resection in the vagina. How should this problem be managed?

Dr. Evans: I certainly would not reoperate immediately. I would allow the vaginal cuff to heal completely and then do a follow up pap smear. If the pap smear were abnormal, I would colposcope the patient.

Dr. Flynt: Apparently small amounts of residual dysplasia are eradicated by the inflammatory process that occurs following hysterectomy. However, it should be emphasized that even in those patients who have no evidence of disease extending to the line of resection, there is an increased risk for the later development of vaginal and vulva carcinoma. For that reason, these patients should be followed more closely than normal and should continue to have pap smears of the vaginal cuff.

Dr. Sampson: Let us assume that the colposcopic findings and colposcopic biopsies were identical. However, the pap smear was suggestive of a more severe lesion than identified on biopsy. Would you manage the problem any differently?

Dr. Evans: One must have good correlation between the colposcopic biopsy and pap smear in order to feel that you can rely on the former.

Dr. Flynt: One must be concerned that the entire lesion was not seen on colposcopy. Although the biopsy might ultimately prove to be correct, one must be concerned about the possible presence of a more severe lesion, and a cervical conization would be mandatory.

Dr. Sampson: How often do you recommend a pap smear to your patients, assuming that they have no past history to cervical intraepithelial neoplasia and that their last pap smear was normal?

Dr. Howe: I do yearly pap smears if there is no history of abnormality.

Dr. Evans: I do too. However, many of you are probably aware of the American Cancer Society recommendation that some patients do not need a pap smear but every third year.

Dr. Sampson: Most people are somewhat confused about the recommendations of the American Cancer Society. They did not recommend pap smears every three years "across the board." They specifically excluded high risk patients from those who could "get by" with a pap smear every third year. They also said that the woman should have two consecutive negative annual pap smears before switching to being seen every three years. Taking this into account along with the multiple risk factors, there are really very few patients who qualify for screening every three years. I agree with the panelists and still recommend yearly pap smears to my patients.

Knowing your pathologist and understanding the pathology report cannot be emphasized too greatly. I am delighted that the panelists made this extremely important point. ★★★

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Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

SPECIAL ARTICLE

Nuclear Waste Storage in Mississippi — An Issue of Health

DON LA GRONE, M.D.
Biloxi, Mississippi

The numerous complex technical issues involved in nuclear waste disposal place exhaustive coverage on all aspects of this subject beyond the scope of this journal, notes the author. He provides in this article a summary intended to serve as a useful introduction, and he also includes a bibliography for those who desire more details. The author notes that this article reflects some conclusions and value judgments resulting from his reading. He concludes that he supports the peaceful development of nuclear energy, but not at the expense of health and safety.

THROUGHOUT THE DEVELOPMENT of the nuclear power industry, from the 1950's to the present, the major priority in the assignment of scientific talent as well as in the appropriation of development financing has been directed toward the front end of the nuclear fuel cycle. That is, those activities extending from the mining of uranium, through its enrichment, and the fabrication of fuel rods, to the production of electricity from light water reactors. Federal agencies and the nuclear power industry assumed that the highly radioactive spent fuel rods, as well as the wastes resulting from our defense industry, would be reprocessed to remove remaining fissionable U-235 and plutonium, and that this reprocessing would solve the dilemma of nuclear waste disposal. Currently, 10.3 million cubic feet of liquid high level wastes from our production of nuclear weapons is stored on federal reservations in Washington and South Carolina. Although a significant problem, this source of waste is not increasing rapidly, and has already been surpassed in amount by wastes generated in the nuclear power industry (see illustration).

Each of our nation's 78 nuclear power reactors generates 30 metric tons of highly radioactive spent fuel rods each year. To date, the spent fuel rods have been stored in interim water baths at each reactor site, awaiting reprocessing. Not until the late 1960's did problems in reprocessing spent fuel become apparent. It was then recognized that the availability of the reprocessing technology would make weapons grade plutonium available to the third world countries to which the nuclear industry planned to export reactors, thus threatening our national goal on nuclear weapons non-proliferation. Likewise, reprocessing did not solve the problem of disposal of the fission products such as Cesium-137 and Strontium-90, which produce the majority of radioactivity and thermal energy from spent fuel for the first few hundred years. Finally, the abundance of uranium on the world market and the relatively high cost of reprocessing spent fuel made the venture economically unattractive and it was cancelled by President Carter in 1977.

Radionuclides, unlike other forms of toxic wastes, cannot be detoxified through chemical or physical reactions. Detoxification occurs only through natural radioactive decay, requiring geologic periods of time. For example, plutonium-239 has a half-life of 24,400 years and will thus remain toxic for over 500,000 years. Some fission products

Dr. La Grone is engaged in the private practice of pediatrics in Biloxi, MS.

such as Technetium-99, which is actively incorporated into biologic systems such as intestinal mucosal cells, has a half-life of 210,000 years.

With the abandonment of reprocessing plans, the only remaining solution to the dilemma of nuclear waste disposal is complete isolation of these materials from all biologic systems for geologic periods of time. Due to the low priority given to waste disposal in the development of the nuclear industry and their reliance on reprocessing as the solution to the waste problem, the basic geophysical research necessary to assure the safe isolation of nuclear wastes has simply not been done. Despite the absence of an adequate scientific base for waste disposal, the nuclear industry has continued to build and license new reactors. Based on industry projections, a backlog of over 72,000 tons of spent fuel is predicted by the year 2000.

In December 1982 the Federal Nuclear Waste Policy Act set out guidelines for the rapid characterization and development of a permanent geologic storage facility for nuclear wastes. This legislation was largely the product of lobbying efforts by the nuclear industry which is eager to continue its reactor sales, but is under public pressure to demonstrate a solution to the waste problem. The timetable set out in the law calls for the nomination in 1984 of five sites for more intensive investigation, three of which would be recommended to the President as primary choices. Mississippi's salt domes have received priority consideration and can be expected to appear on this list. The law further allows for the placement of up to 100 tons of high level wastes (containing over 30 billion curies of radiation) in a potential site during the testing phase, without either licensing of the site by the Nuclear Regulatory Commission or a full environmental impact statement. During the evaluation phase, the Department of Energy regulations forbid any on-site tests which would jeopardize the availability of the site as a final repository. Crucial tests such as accidental flooding of shafts, simulated explosions and electrical fires, as well as the drilling of test holes around the repository site to assess thermal and geologic effects on the site are thus forbidden.

To embark on storage in deep geologic formations such as Mississippi's salt domes before basic geophysical research is completed to assure the safety of the program over the extremely long periods necessary for radioactive decay is a dangerous "quick-fix" solution to a complex scientific problem.

Examination of the safety record for storage of wastes by the nuclear industry and federal government does not inspire confidence. At the Hanford, Washington nuclear storage site, this nation's oldest and largest such facility, over 600,000 gallons of high level defense wastes have leaked from steel tanks into the soil, permanently contaminating the site and threatening the Columbia River. One leak of 115,000 gallons went unrecognized for over 55 days despite daily monitoring of decreasing levels on the corroded tank. Similar contamination has occurred at Maxey Flats, Kentucky and West Valley, New York. In each case, hastily reached technologic decisions, based upon insufficient basic scientific data were accepted as political expedients and led to systems failures and contamination of the environment.

The case against salt dome storage of nuclear wastes is a strong one. Salt is highly corrosive. Salt does not chemically bind radionuclides as other rocks do and thus cannot prevent their migration if leakage occurs. Salt domes contain water, both chemically complexed to the salt molecules and as brine pockets within the domes. Waste cannisters have a temperature of 575° F. In salt, water as liquid and vapor is drawn toward heat sources. In other rocks it is driven away. Salt becomes plastic at high temperatures. Waste cannisters could be expected to sink from their sites and move toward one another, thereby generating more heat and increasing water migration. The EPA has stated that when exposed to conditions of heat and brine, available outer steel cannisters could not be guaranteed for longer than 10 years. Once the outer cannister is breached, the exposed ceramic/glass solidified wastes would decompose completely in less than one month. The plasticity of salt and resulting migration of cannisters would make retrieval impossible after as little as 10 years. Since released radionuclides are not chemically bound to the salt, leakage into the silty sand layers surrounding the salt domes would be likely, thus contaminating the source of ground water for the entire Mississippi gulf coast region.

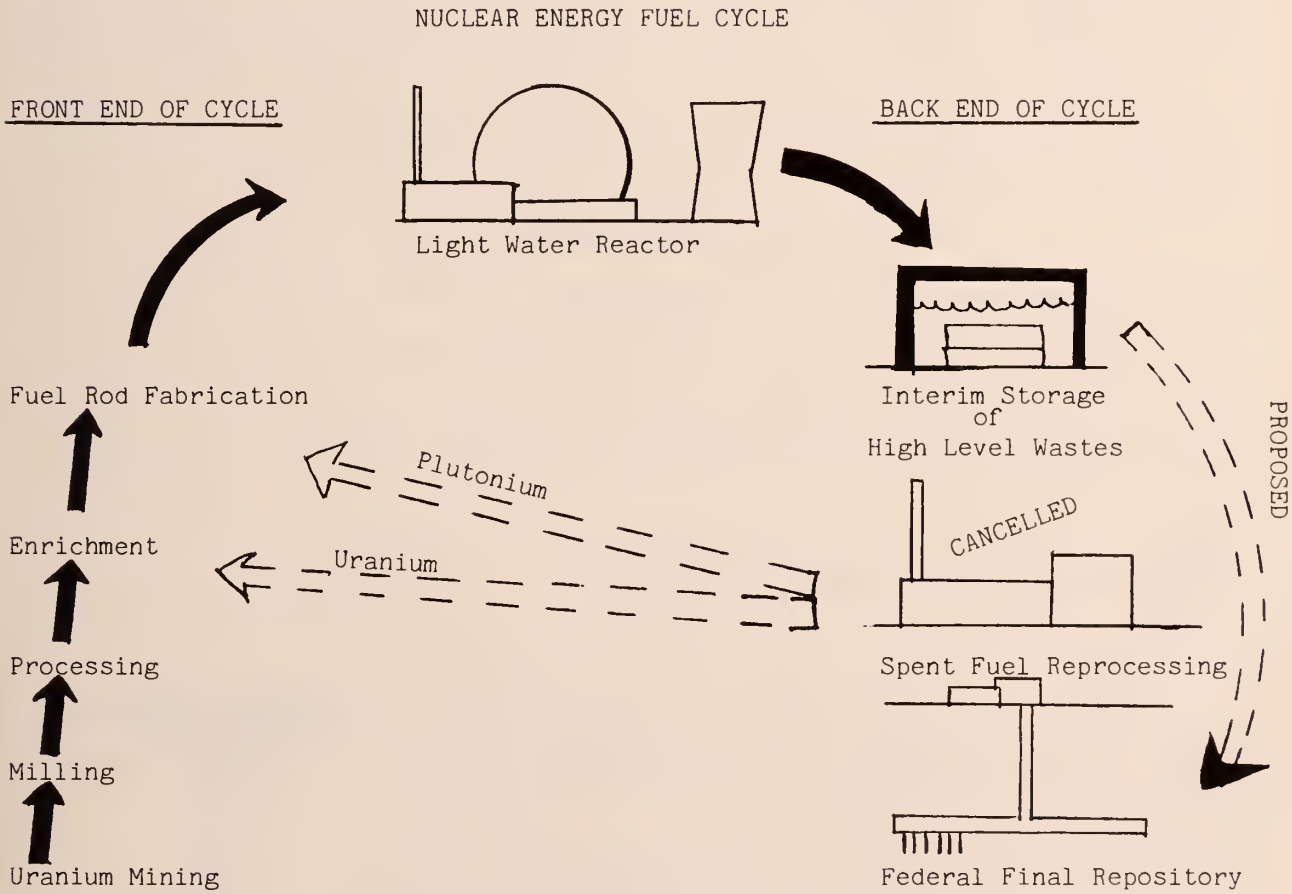
Nuclear waste disposal is a health issue because all the negative consequences are medical in nature. Exposure to ionizing radiation produces biochemical alterations in cells leading to genetic aberrations and cancers. Based on epidemiologic data, a one Rad-per-person exposure to a population of one million would be expected to produce 100 excess deaths from leukemia and other cancers, as well as 160 genetically damaged children in the first generation. The effects of radiation are greatest in the young and in rapidly growing tissues. In utero exposure of the

fetus has been shown to increase the incidence of death from cancer before age 10 years by 50%. The effects of low level exposure to radiation are cumulative and produce alterations which may not be manifest for years. Health physicists state that there are no absolutely safe lower levels of exposure. British nuclear dockyard workers exposed to levels of radiation well within accepted safety standards have been found to have increased rates of chromosomal aberrations. Despite government assurrances of safety, the residents of Nevada and Utah who were exposed to fallout from the 1957 above ground nuclear weapons tests have experienced a greatly increased incidence of leukemia.

Clearly, all exposure to ionizing radiation should be limited to situations in which commensurate benefits are expected. The development of a high level nuclear waste repository at Richton or Cypress Creek prior to the availability of scientific documentation of the safety of geologic storage in salt will impose a grave risk to the health of Mississippians, both in this generation and for many generations to come. A reasonable alternative to the "quick-fix" solution sought by the nuclear industry would contain several elements:

(1) Licensing of new reactors must be linked to solution of the disposal problem.
(2) The government and nuclear industry must reorient their priorities, assigning the best available scientific talent to the back end of the nuclear fuel cycle.

"The case against salt dome storage of nuclear wastes is a strong one. . . . The development of a high level nuclear waste repository at Richton or Cypress Creek prior to the availability of scientific documentation of the safety of geologic storage in salt will impose a grave risk to the health of Mississippians. . . ."



The current dilemma of what to do with nuclear wastes is a direct result of the low priority given to technical development of the "Back End" of the Nuclear Fuel Cycle.

(3) In order to obtain increased credibility and technical capacity, the industry and government should encourage independent research by universities and professional societies, instead of commissioning private research companies with vested interests in nuclear power. In addition they should encourage objective critical review of all research through publication in professional journals, etc.

(4) During the period of time necessary for basic research, spent fuel can be stored on the reactor sites where it is generated by enlarging existing storage pools. This has the benefit of assigning the greatest risks from nuclear waste storage to the areas receiving the benefits of nuclear power. It also avoids the high risk of transporting this material over our nation's highways and railbeds. Finally it avoids the imposition of risk on the people of Mississippi as a political expedient before the safety of geologic storage can be assured. ★★★

Coastal Medical Center (39531)

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The President Speaking

A Look at Competition

Ellis M. Moffitt, M.D.
Jackson, Mississippi

Competition in any industry is affected by four basic forces: (1) demand for the product or services; (2) the industry's ability to supply its product or services; (3) consumer attitudes toward the industry; (4) the role that government takes with respect to the industry and other system constraints.

A number of changes are taking place now within the health care field that will increase competition among health care providers and create the need for better practice management strategies.

While the product that physicians are capable of delivering to patients will change substantially with technological advances, the demand for that product will be affected by three factors: (1) people — the number of potential patients classified by age, geographic location, and other demographics; (2) ability to pay — personal resources coupled with employer benefits or societal assistance; (3) willingness to spend these resources on a specified good or service available in the economy.

A number of demographic trends are taking place that will affect the demand for medical service. The fastest growing segment of the population from 1980-2000 will be the 40-60 age group — a group that will have the highest need for medical service but also the ability to pay for what it wants from employer benefits or personal resources.

Current population trends also indicate that the percentage of the population over 65 will increase. The 65 and over group will account for 70% of hospital use by the year 2000 and 99% of hospital services by the year 2020, in contrast with 38% by 1985.

Another factor is changing lifestyles — because institutions that determine lifestyles are currently undergoing rapid change. Today's lifestyles increasingly support a shift away from "self denial" to a focus on "self." There is a need to look good, feel good and be healthy at any cost. With this drive of the "me," patients are taking into their own hands control of their health care, ie, exercise, nutrition, spending enormous sums on OTC medications for relief and prevention of illness. The demand side of medical care looks promising.

Much of the cause of our current illness lies in our individual and collective behavior and in our physical and social environments. Future improvements in health care can result from

(Continued on page 179)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXV, Number 7

JULY 1984

Journal Advertising

Numerous inquiries have been received over the past several weeks regarding policies for advertising in the JOURNAL MSMA. All have questioned publication of an advertisement from an out-of-state medical center. All of those commenting thought it inappropriate for the association's journal to carry advertisements inviting competition with instate physicians. Some even expressed the opinion that all advertisements should be discontinued if it was necessary that such ads be carried in the journal.

Advertisements for the journal are obtained in two ways: (1) the staff solicits ads from local businesses, and (2) the State Medical Journal Advertising Bureau (SMJAB) solicits ads from national businesses for publication in one or more of its member journals.

The controversial ad was submitted from the national organization. Recent contacts with management of SMJAB reflect that Mississippi is not the only state concerned with the publication of out-of-state advertisements which conflict with physicians in the given state. We were also informed by SMJAB that the advertisement in question had been withdrawn.

As a result of this problem, the Editor has requested the right to review all future ads from SMJAB, except those obtained from pharmaceutical companies.

In addition, the MSMA legal staff is being consulted regarding the position of the journal in refusing to accept specific ads.

In response to those requesting that the journal do away with all advertising, it should be emphasized that such advertisement pays a major portion of the cost of publication for your journal. Total costs average approximately $60,000 per year, and approximately one-half of this is obtained from advertisements. Loss of this amount would severely jeopardize publication of the journal on its current basis. This needs to be avoided if at all possible and, therefore, the journal staff will continue to solicit and accept advertisements. Any directions to discontinue this policy would have to come from the MSMA Board of Trustees and House of Delegates.

MYRON W. LOCKEY, M.D.
Editor

THE PRESIDENT SPEAKING

(Continued from page 178)

changes in our attitudes toward these areas as well as from improvements in the health care system. A new approach to a healthy society might be an effort to make medicine much more prevention-oriented. This approach would determine the major cause of illness and develop a deliberate and coherent set of public policies intended to create a healthy society. The fitness craze currently sweeping the country, for example, is leading us to a major change in the delivery of health care.

The role of government is a factor. Government is moving away from national health insurance and regulation is decreasing. Medicare and Medicaid are being decentralized and becoming a state government responsibility. In place of regulation the government is contemplating competition. A number of bills in Congress would eliminate government mandated health planning and phase out Medicare and Medicaid. All of us would compete on equal terms with insurance carriers, HMOs, IPAs, PPOs. The reason the government is moving away from regulation is that, simply stated, it has not worked. Competition is thought to be the best way to ensure quality care at a reasonable cost.

Are you ready for the competitive forces about to move into our area? What role would your state medical association assume in the competitive world? Should we have all of the resources available for you as a local medical society in the event you are forced to compete in an unfamiliar contract negotiation or a marketing plan for your practice? How do you plan to maintain your current patient load or rate of economic growth?

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Dr. Moffitt Is Inaugurated, Dr. Brock Named President-Elect

Dr. Ellis M. Moffitt of Jackson was inaugurated 1984-85 president of the MSMA at the closing meeting of the 116th Annual Session held last month in Biloxi. He succeeds Dr. Whitman B. Johnson of Clarksdale. Dr. Ralph L. Brock of McComb was named president-elect.

More than 900 registered for the five-day session, which featured a full program of scientific, business and fellowship activities.

Special guest speaker at the opening session of the House of Delegates on Thursday was Dr. Frank J. Jirka, president of the American Medical Association.

The scientific program featured two plenary sessions. More than 15 speakers from across the country made presentations at the general sessions and at medical specialty organization meetings.

Highlighting the scientific program was the presentation of the fourth annual James Grant Thompson Memorial Lecture, which was delivered by Dr. Phillip Gorden of the National Institutes of Health, Bethesda, Maryland.

The House of Delegates handled a heavy business agenda which included elections to fill vacancies in MSMA offices, action on more than 25 reports and resolutions, and presentation of awards. A summary of House of Delegates actions appears on pages 187 and 188 of this issue.

Dr. Ellis M. Moffitt of Jackson, right, was inaugurated president of the association during the 116th Annual Session. With him, from left, are Dr. Whitman B. Johnson of Clarksdale, immediate past president, and Dr. Ralph L. Brock of McComb, 1984-85 president-elect.

Dr. J. O. Manning, right, administers the oath of office to Dr. Ellis M. Moffitt, left, assisted by Charles Mathews, MSMA executive director, and Dr. Whitman B. Johnson, 1983-84 MSMA president.

Top right, Dr. Johnson receives the James Grant Thompson Memorial Past President's Pin from Mrs. Thompson. At right is Dr. Carl Evers of Jackson, speaker of the House of Delegates.

Following his inauguration, Dr. Moffitt is congratulated by former MSMA president Dr. Everett Crawford, at right.

Dr. Sidney O. Graves of Natchez, MSMA immediate past president, presents Dr. Johnson with a certificate of appreciation from the Past President's Club.

Dr. Johnson addresses the House of Delegates.

Elections Highlight House of Delegates Sessions

In addition to electing Dr. Ralph Brock of McComb to the post of president-elect, delegates to the 116th Annual Session cast ballots to elect other MSMA officers.

Dr. Martin McMullan of Jackson and Dr. David Owen of Hattiesburg were elected to terms on the Board of Trustees. Dr. David Steckler of Natchez and Dr. Roy Duncan of Pascagoula were re-elected to the Board.

Two AMA delegate posts and two alternate delegate posts were filled. Drs. Lamar Weems of Jackson and Sidney Graves of Natchez will serve as AMA delegates. Drs. Whitman Johnson of Clarksdale and Carl Evers of Jackson will serve as alternate delegates. Dr. Evers was also re-elected as speaker of the House of Delegates. Dr. James Waites of Laurel was named to another term as vice speaker.

Dr. Tom Glasgow, Oxford, was elected vice president from the north district. Dr. Arthur Derrick of Durant was re-elected associate editor, JOURNAL MSMA.

Fifteen physicians were elected to the following councils: Council on Budget and Finance — Drs. George Ball and Francis Morrison, both of Jackson; Council on Constitution and Bylaws, Dr. Frederick Tatum of Hattiesburg; Judicial Council — Drs. Arthur Derrick of Durant, Fred McMillan of Jackson, and Walter Gunn of Quitman; Council on Legislation — Drs. Robert Cooke of Hattiesburg, H. Vann Craig of Natchez, and C. D. Taylor of Pass Christian; Council on Medical Education — Drs. L. Stacy Davidson of Cleveland, Horton G. Taylor of Ripley, and J. M. Patterson of Pontotoc; and Council on Medical Services — Drs. Virginia Tolbert of Ruleville, James Rayner of Oxford, and Steve Parvin of Starkville.

Board of Trustees Elects New Officers

Dr. W. Joseph Burnett of Oxford was elected chairman of the MSMA Board of Trustees during the board's meeting May 20 in Biloxi. Dr. William C. Gates of Columbus was named vice chairman and Dr. Roy D. Duncan of Pascagoula was elected secretary.

Other members of the board are: Drs. Virginia Tolbert, Ruleville; William B. Hunt, Grenada; David Steckler, Natchez; Martin McMullan, Jackson; C. G. Sutherland, Jackson; George L. Arrington, Jr., Meridian; David M. Owen, Hattiesburg.

Dr. Ralph L. Brock of McComb, 1984-85 MSMA president-elect, addresses the House of Delegates.

Dr. Martin McMullan of Jackson, left, and Dr. David Owen of Hattiesburg were elected to the Board of Trustees.

Representatives of the MMPAC board received three AMPAC awards from Dr. Frank Jirka, AMA president. Standing, from left, are: Dr. Rod Jenkins of Laurel, Dr. Edwin Hemness of Clarksdale, and Dr. Edward Pennington of Ackerman. Seated at left is Dr. J. O. Manning of Jackson, chairman of the MMPAC board. The awards and categories which MMPAC won are: first place, Contributions Per Member; third place, Members to Potential; and second place, All Events.

Dr. Norman A. Nelson, dean of the University of Mississippi School of Medicine, second from left, accepted from Dr. Johnson checks for $20,242.80 and $2,115.00, representing 1983 unrestricted and medical education contributions to the medical center. On hand for the presentation were Mrs. Enrique Flechas of Natchez, MSMA Auxiliary AMA-ERF chairman, and Dr. Don Q. Mitchell of Jackson, right, president of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

Dr. Lester D. Webb of Calhoun City, right, received the 1984 MSMA-Robins Award for Community Service. Phil Taylor of Hattiesburg, center, represented the A. H. Robins Company and assisted Dr. Johnson in making the presentation.

Members of the House of Delegates prepare to mark ballots.

Members of the House of Delegates prepare to vote. In the foreground, from left, are Dr. Guy Vise, Sr., Dr. Reginald P. White, and Dr. Stanley A. Wade, all of Meridian.

House of Delegates

Dr. Fred Ingram of Jackson, left, looks over a report, as Dr. John Paul Lee of Forest confers with Dr. Myron Lockey of Jackson. The three were members of the Central Medical Society delegation.

116th Annual Session, May 16-20, 1984

HOUSE OF DELEGATES HANDLES BUSY AGENDA

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of reports and resolutions at the 16th Annual Session of the association in Biloxi. The official transactions of the meeting will be mailed to all delegates.

The MSMA House of Delegates took these major actions:

- Adopted amendments to the MSMA Constitution and Bylaws which among other things reorganizes the House of Delegates and scientific program format.
- Approved a building program to house the association and its related programs, the Medical Assurance Company of Mississippi and the Mississippi Foundation for Medical Care.
- Directed the Board of Trustees to study the feasibility of setting up PPOs and/or IPAs in areas of the state where the membership and their patients desire such programs.
- Went on record to oppose storage of nuclear waste in the salt domes of Mississippi.
- Directed the Council on Medical Service to study and develop methods to judge competency of physicians to practice medicine.
- Established a hospital medical staff section which will meet at annual sessions of the association as a forum to discuss issues affecting hospital medical staffs.
- Approved an informational brochure on breast cancer for distribution to physicians and their patients.
- Established a Council on Public Relations.
- Urged all third party payors to adopt Medicare phraseology on payments to physicians — namely "amount approved."
- Urged that studies of the effects of agricultural chemicals on fish and other wildlife be expedited.
- Restated association support for nominal co-payments on Medicaid services.
- Restated association support for physician representation on hospital governing boards.
- Endorsed the concept of outpatient education of patients with diabetes.
- Expressed support for a freeze on physicians' fees as previously endorsed by MSMA's Board of Trustees.
- Urged each member of the association to use the AMA's Patient Medication Instruction (PMI) program.
- Directed that projections of an oversupply of health professionals be brought to the attention of appropriate educational and public officials in the state.
- Restated support for a medically needy program for mothers and children under Medicaid and for adequate funding of basic required services.
- Restated support for raising the legal age for purchasing alcohol in the state to age 21.
- Adopted terminology clarifying drug substitution issues and stated opposition to any concept of therapeutic substitution of drugs by pharmacists.
- Approved a technical exhibit section beginning with the 1985 Annual Session.
- Urged all Mississippians to avail themselves of first aid training.

- Endorsed legislation requiring hunters to participate in a Hunter Safety Program.
- Awarded the 1984 MSMA Robins Award for Community Service to Dr. Lester D. Webb of Calhoun City.
- Presented $22,357.80 to the University of Mississippi School of Medicine representing 1983 AMA-ERF contributions to the school from Mississippi physicians and spouses.

Serving on reference committees of the House were:

Reference Committee on Rules and Order of Business

Stanley A. Hill, M.D., Chairman
Gerald P. Gable, M.D.
Edward Pennington, M.D.

Reference Committee on Reports of Officers, Board of Trustees and Councils

L. Stacy Davidson, M.D., Chairman
Jerry R. Adkins, M.D.
Joseph E. Johnston, M.D.
Lee H. Rogers, M.D.
Richard M. Vise, M.D.

Reference Committee on Constitution and Bylaws

Frederick E. Tatum, M.D., Chairman
Everett H. Crawford, M.D.
Max L. Pharr, M.D.

Credentials Committee

J. Elmer Nix, M.D., Chairman
George C. Furr, M.D.
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Charles L. Wilkinson, M.D.
James C. Waites, M.D.
Mal G. Morgan, M.D.
Thomas R. Singley M.D.

117th Annual Session
May 15-19, 1985 (Wednesday-Sunday)
Royal d'Iberville Hotel, Biloxi

Guest speaker Willard Scott appeared without his toupee, but quickly spotted a likely candidate in Dr. Ellis Moffitt.

Willard Scott and MSMA Auxiliary president Mrs. Ted Blanton.

MSMA Membership/Auxiliary Banquet

Mrs. Whitman Johnson poses with Willard Scott and Dr. Frank Jirka.

MSMA and Auxiliary members gathered at poolside for an old fashioned political rally, complete with Dixieland band, hot dogs, popcorn, watermelon, flags and balloons.

Poolside Political Rally

Dr. J. O. Manning, chairman of the MSMA Board of Trustees and of the MMPAC Board, introduced speakers for the political rally.

Congressman Webb Franklin addresses the crowd.

Congressman Wayne Dowdy, second from left, talks with Dr. Ralph Bell, left, and Dr. Ellis Moffitt. At right is Dr. Henry Sanders of McComb, Dowdy's campaign chairman.

Dr. Alfio Rausa of Greenwood, right, talks with Congressman Webb Franklin. At left is Dr. Whitman Johnson, 1983-84 MSMA president.

Dr. Frank Tucker of Meridian, left, presided at the Surgery Plenary Session. He is pictured with Dr. Watts Webb of Tulane, during a question and answer session following Dr. Webb's address.

Dr. Billy W. Long of Jackson, center, chairman of the planning group for the Medicine Plenary Session, is pictured with guest speakers Dr. Sidney Cohen of Philadelphia, Pennsylvania, left, and Dr. Phillip Gorden of Bethesda, Maryland, who delivered the James Grant Thompson Memorial Lecture.

Special Guests

Above, Dr. Jirka appeared on a local television talk show. At left, Dr. Jirka responds to a news reporter's questions.

Dr. Stanley Hill, chairman of the Reference Committee on Rules and Order of Business, makes his report.

Dr. Fred Tatum reports to the House of Delegates on actions of the Reference Committee on Constitution and Bylaws.

Dr. L. Stacy Davidson, chairman of the Reference Committee on Reports of Officers, Councils, and Board of Trustees, describes the committee's recommendations.

House of Delegates in session.

Members of the Past Presidents' Club were photographed as they gathered for their annual breakfast. Seated, from left to right, are: Dr. Frank Jirka, AMA president; Dr. Stanley Hill; Dr. J. T. Davis; Dr. Guy Vise, Sr.; Dr. Omar Simmons; and Dr. Lawrence Long. Standing, left to right, are: Dr. Everett Crawford; Dr. Whitman B. Johnson; Dr. James O. Gilmore; Dr. Paul Moore; Dr. Jimmy Royals; Dr. Arthur Derrick; Dr. Gerald Gable; Dr. Rod Jenkins; Dr. Sidney Graves; Dr. Faser Triplett; and Dr. Carl Evers.

Past Presidents / Fifty Year Club

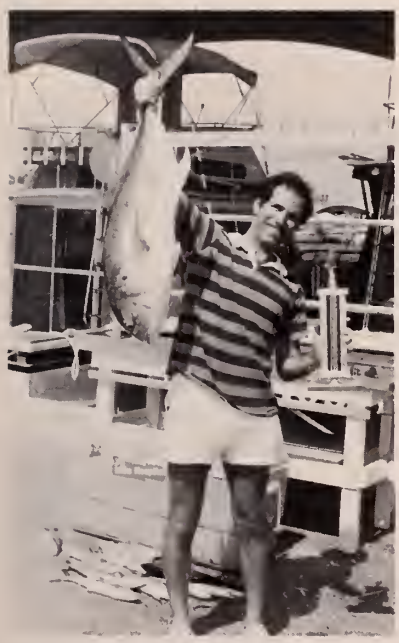
Above, Dr. J. Gordon Dees of Jackson, left, was inducted as a new member of the Fifty Year Club. He is pictured with Dr. Lawrence Long of Jackson.

At right are members of the Fifty Year Club. From left are: new member Dr. Joseph Kuljis of Biloxi, Dr. G. T. Sheffield of Gulfport, Dr. Guy Vise of Meridian, and Dr. Omar Simmons of Newton.

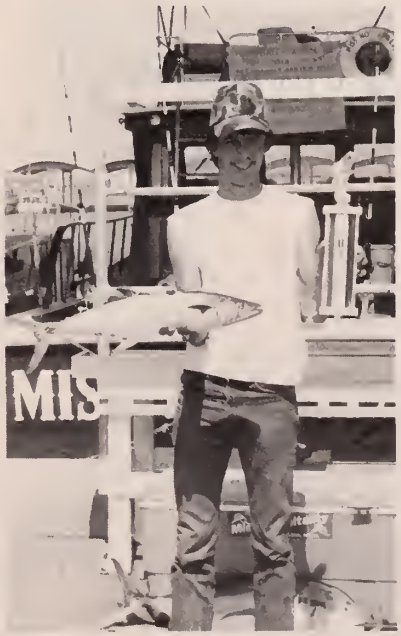
Dr. Bill Gates presents men's championship trophies to Dr. John Fair Lucas, Jr., left, and Dr. Hal Flowers.

Winners of the women's doubles competition, Martha Whitehead, left, and Marianne Spence, right, receive their trophies from Dr. Gates.

Special Events



Dr. Allen Harris displays the trophy he received for catching the largest jack crevalle in the annual fishing rodeo.



Ray Allard, son of Dr. George D. Allard, won the trophy for catching the largest mackerel during Friday's competition.

Eric Pendergrass, son of Dr. John Pendergrass, displays the trophy for largest mackerel caught in Saturday's competition.

Past presidents of MSMA Auxiliary gathered for their annual breakfast.

MSMA Auxiliary Annual Session

Mrs. Ted Blanton, seated at center, was installed as 1984-85 president of the MSMA Auxiliary. Mrs. Ben Martin, seated left, was named president-elect. Seated at right is Mrs. James Waites, first vice-president. Standing, from left are: Mrs. John P. Mladineo, third vice president; Mrs. T. E. Ross, parliamentarian; Mrs. William C. Hopper, second vice-president; Mrs. Anthony C. Fouts, recording secretary; and Mrs. Stanley Hartness, treasurer and immediate past president. Not pictured are Mrs. M. E. Hinman, fourth vice-president, and Mrs. Don Mitchell, corresponding secretary.

Among delegates to the MSMA Auxiliary House of Delegates were Dr. Nina Moffitt and Dr. Ellis Moffitt, who are members of both MSMA and MSMA Auxiliary.

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See important information on next page.

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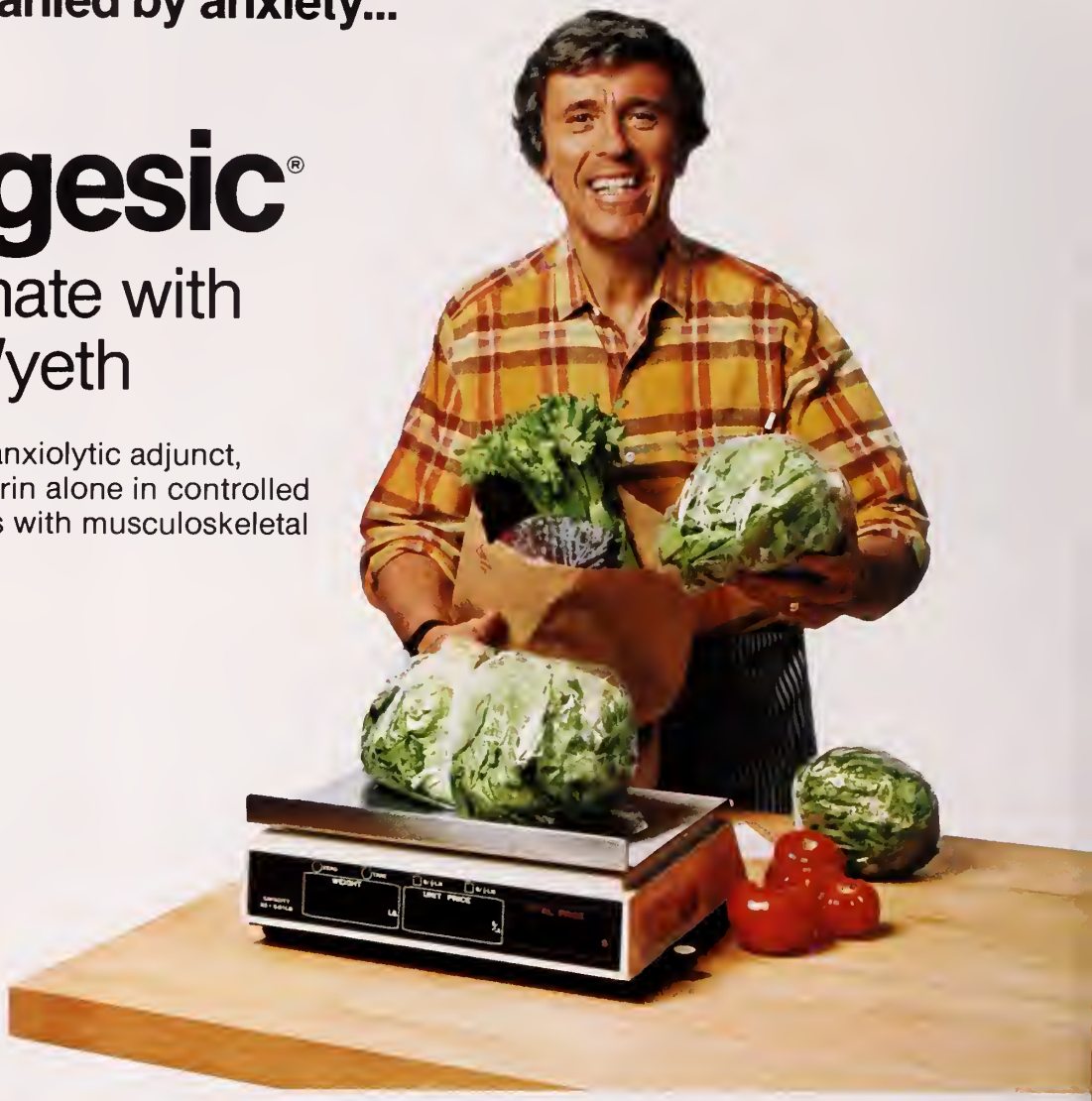
An effective analgesic/anxiolytic adjunct, proven superior to aspirin alone in controlled clinical trials in patients with musculoskeletal disorders.



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(BRIEF SUMMARY)

DESCRIPTION:
Each tablet contains 200 mg meprobamate and 325 mg aspirin

INDICATIONS:
Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED:
Scored tablets: bottles of 100, Redipak® strip pack 25 s, Redipak® unit dose 100 s, individually wrapped.

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Dr. Virginia Tolbert, chairman of the Nominating Committee, reports to the House of Delegates.

Dr. James Waites, vice-speaker of the House of Delegates, conducted part of the proceedings.

MSMA staff person Lora Lane, coordinator of the association's GTE and CommuniCare programs, was on hand with exhibits about both. Here she talks with Dr. L. C. Henson, left, and Dr. Randy Tillman.

Dr. Elmer Nix, MSMA secretary-treasurer, announces attendance figures for the 116th Annual Session. With him at left is Dr. Carl Evers, speaker of the House of Delegates.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

Aug. 18
OPHTHALMOLOGY UPDATE 1984
Holiday Inn Downtown, Jackson

Sept. 6
BULIMIA AND ANOREXIA NERVOSA
Holiday Inn North, Jackson

Oct. 4-5
FAMILY PRACTICE UPDATE
Jackson

Oct. 26-27
ANNUAL PEDIATRIC MEETING
University Medical Center, Jackson

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Officers for the American College of Surgeons, Mississippi Chapter, include, from left, Dr. Vann Craig, president, Dr. Ralph Abraham, secretary, and Dr. Jerry Adkins, president-elect.

Dr. Arthur Matthews, left, was elected president of the Mississippi Urological Society. With him is Dr. James Robbins, society secretary.

Attending one of the receptions were, from left, Dr. William Sistrunk, Dr. Richard Miller, and Dr. and Mrs. William Wiener.

MEETINGS

National and Regional

American Medical Association, Annual meeting, June 16-20, 1985, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 117th Annual Session, May 15-19, 1985, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi, Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501 Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties. Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38665. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Dan Jones, Secy., P.O. Box 2756, Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N State Street
Jackson, MS 39201

Gulf Coast Community Hospital
4642 W Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Delta Medical Center
P.O Box 5247
Greenville, MS 38701

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

Oxford-Lafayette County Hospital
P O Box 946
Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital
969 Lakeland Dr.
Jackson, MS 39216

PERSONALS

John M. Abide announces the opening of his office for the practice of dermatology and skin cancer surgery at 1316 Hospital Street in Greenville.

Orlando Andy of UMC presented a paper at the Neurosurgical Society of America meeting in Coronado, California and also presented a paper and poster sessions at the Society of Biological Psychiatry Assembly in Los Angeles.

Blair E. Batson of UMC was in San Francisco as examiner for the American Board of Pediatrics.

John R. Bise of Jackson conducted a roundtable session at the annual meeting of the American College of Obstetricians and Gynecologists in San Francisco.

Charles E. Catchings of Woodville has been named recipient of the 1984 Gerard Brandon Award presented by the Woodville Civic Club in recognition of outstanding contributions to the community.

James E. Clarkson of Biloxi has been appointed liaison associate of the Commission on Cancer at Biloxi Regional Medical Center by the American College of Surgeons.

Norman Duane Ervin has associated with The Family Clinic, 502 Broad Street in Columbia, for the practice of family medicine.

Alan E. Freeland of UMC served on the faculty of a University of Minnesota sponsored course in Colorado Springs, Colorado.

William J. Gibson announces the opening of the Breast and Thyroid Clinic, 1045-B North Flowood Drive in Jackson.

Glen R. Graves of UMC presented a workshop in Clarksdale recently.

William G. Hardin of Meridian has been certified by the American Board of Gastroenterology.

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Michael E. Jabaley was elected vice president of the American Society for Surgery of the Hand at its annual meeting in Atlanta.

James M. Hodges has associated with Larry J. Hammett for the practice of otolaryngology at 101 Courtenay Circle in Hattiesburg.

Robert L. Jordan Jr. announces the opening of his office for the practice of family medicine and pediatrics at 5002 Highway 39 North in Meridian.

John Kapp of UMC was examiner for the American Board of Neurology in Memphis and presented a paper at the American Society of Clinical Oncology assembly in Canada.

The annual fund-raising party in Pass Christian to benefit the Mississippi Chapter of the American Heart Association will honor Wesley W. Lake, in recognition of his service and support in the fight against heart disease.

Bob Lampton of UMC spoke to the Tylertown Rotary Club about the programs of the Mississippi Heart Association.

Herbert Langford of UMC was a guest speaker for a recent hypertension conference in Mobile, Alabama, and presented an abstract at the American Society of Clinical Research in Washington, DC.

Edward M. Lowicki of Jackson has been elected chairman of the Association of Hospice Physicians, National Hospice Organization.

Lawrence M. Martin announces the opening of his office for the practice of psychiatry at Coastal Medical Center, Gateway Executive Drive, in Biloxi.

Rodney Meeks of UMC gave a grand rounds presentation to members of the medical staff at Northeast Mississippi Regional Medical Center in Tupelo.

Wafford H. Merrell, Jr. of Jackson has been appointed to the governing board of St. Dominic-Jackson Memorial Hospital.

Frank J. Morgan, Jr. of Jackson was elected vice-chairman of the FLEX Board at the annual meeting of the Federation of State Medical Boards in San Antonio, Texas. He was also appointed to a special task force on invalid, false or fraudulent educational credentials.

Francis Morrison of UMC was in Oklahoma City and New Orleans as a quality control inspector for the Southwest Oncology Group.

John Morrison of UMC was speaker at meetings in Palm Beach and Orlando, Florida, and in Puerto Rico.

Howard Nichols of UMC was in San Francisco as examiner for the American Board of Pediatrics.

Leon C. Parks of Jackson was elected to the Board of Directors of the International Clinical Hyperthermia Society at its meeting in Como, Italy, where he was a program speaker. He also delivered an address at the Regina Elena Cancer Institute in Rome.

Gary J. Pearce announces the opening of his office for the practice of ophthalmology at 200-C Oak Lane Professional Center in Biloxi.

Michel Rivlin of UMC presented a paper at the annual meeting of the American College of Obstetricians and Gynecologists in San Francisco.

G. Boyd Shaw of Jackson was elected a representative director of the American Lung Association Board of Directors.

Clinton Smith of Laurel spoke at a meeting of the Mississippi Residential Child Care Facility Association recently.

Horton Taylor of Ripley has been elected chief of staff at Tippah County Hospital.

David L. Walt has associated with Family Medical Clinic, 803 First Street, Cleveland, for the practice of internal medicine.

James D. Williams has associated with Iuka Clinic, 1413 West Quitman Street, for the general practice of medicine.

The Mississippi State Medical Association is grateful to the following companies for their financial support of the 116th Annual Session:

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PLACEMENT SERVICE

Situations Wanted

OTOLARYNGOLOGIST currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

BOARD CERTIFIED head and neck surgeon now finishing facial plastic surgery fellowship. Desire opportunity or association in which to develop facial plastic and reconstructive surgery practice. Contact Donn R. Chatham, M.D., 1516 South 20th St., Birmingham, AL 35205; (205) 933-8799 or 871-0429.

Physicians Wanted

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN. Ideal practice opportunity in thriving central Mississippi community of 5,000. Surrounding trade area has 25,000 population base. Excellent opportunity for OB practice if desired. Situated within one hour's drive of Jackson. Reply to Box B, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

FAMILY PRACTITIONER for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

FULLY EQUIPPED ob-gyn clinic available for immediate occupancy. Trade area of approximately 50,000 persons; modern hospital; no other obstetricians in immediate area. Contact Mr. James Townsend, Administrator, Bolivar County Hospital, Cleveland, MS 38732, or call (601) 846-2550.

COMMUNITY seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

GENERAL SURGEON wanted in Union, Mississippi. Seven referring GPs; attractive guarantee; office space furnished. Contact Margaret Muse or John Bradshaw, Laird Hospital, Union, MS 39365; (601) 774-8214.

FAMILY PRACTITIONER wanted for west central Mississippi town in Hinds County, population 1,000 — draws trade from four counties; less than 30 miles to hospitals; good highways. Facilities can be provided if desired. Call (601) 885-8718 or write to Mayor James Keith, P.O. Drawer K, Utica, MS 39175.

COMMUNITY seeks general surgeon. Contact Mr. William E. Rutledge, Administrator, Tishomingo County Hospital, Iuka, MS 38852.

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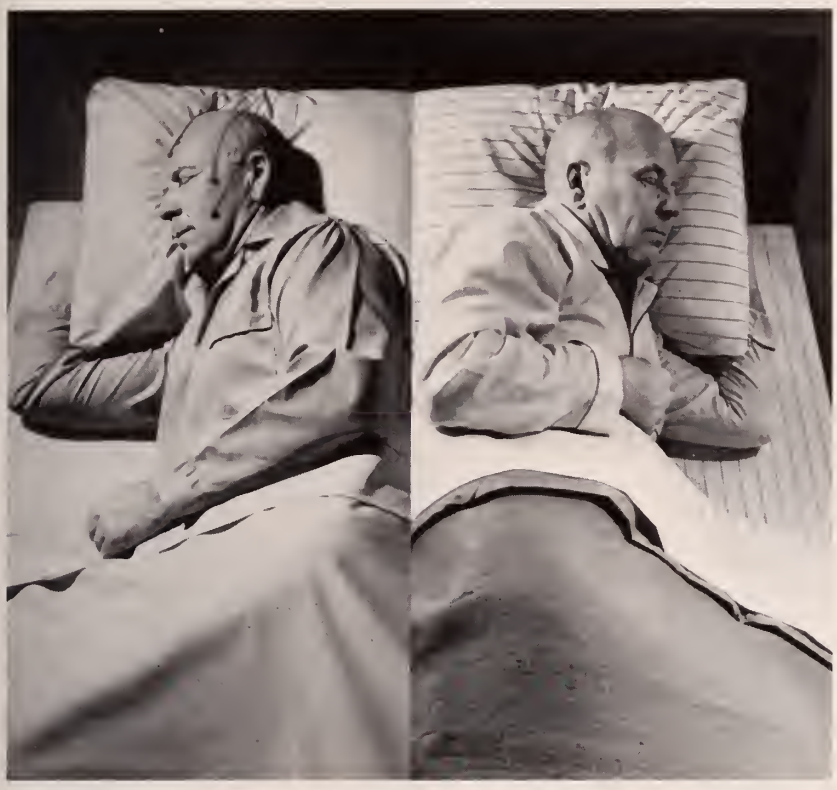

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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Genatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM. *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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August 1984

JOURNAL of the MISSISSIPPI State Medical Association

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NEWSLETTER

August 1984

Dear Doctor:

Physician attestation statement, although modified, continues to be objectionable and should be eliminated, the AMA maintained in a letter to the chief of the Health Care Financing Administration. The letter listed nine specific objections to the proposed requirement of the prospective payment system (PPS) regulations.

> While the modifications are an improvement, they fail to recognize the fact that such a physician attestation is unnecessary, the letter said. The AMA has been meeting with government officials to resolve the issue.

Defensive medicine may add as much as $15.1 billion to the nation's medical bill, according to the AMA Committee on Professional Liability. Two bills have been introduced in Congress to deal with medical liability issues. The AMA supports neither bill but welcomes the opportunity for national discussion of the issue, a statement said.

DRG Monitoring Project is collecting observations of individual physicians about the impact of the new prospective pricing system in their hospitals. The AMA will use the information in pursuing modifications to the PPS and for developing programs to assist physicians in dealing with it. Physicians are invited to send their written comments to the DRG Monitoring Project, AMA Dept. of Health Care Resources, P. O. Box 10947, Chicago, IL 60610.

The Mississippi Foundation for Medical Care (MFMC) received notice June 29 of designation as the state's Professional Review Organization (PRO). To date contracts have been awarded in only 12 states. The objectives and procedures of the PRO system are described in an article in this issue. The article was based on an interview with J. S. McIlwain, Jr., M.D., medical director of the MFMC, who commented on what the new system will mean as it is implemented in Mississippi. PROs will monitor care provided to hospitalized Medicare patients and will have mechanisms for private review and review under Medicaid.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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DATELINE

Task Force to Study Liability Problem

Chicago, IL - A special task force on professional liability has been created by the AMA Board of Trustees. The average incidence of claims has risen from 3.3 per 100 physicians before 1978 to 8.0 per 100 physicians between 1978 and 1983. Claims in health care have increased more rapidly than in any other segment of litigation.

Genetics Center Located at Keesler

Keesler, AFB - The Air Force's only genetics clinic is located at Keesler Air Force Base in Biloxi. The center, which opened in 1980, treated more than 1,000 new patients last year. Staff physicians Col. Barry H. Thompson and Maj. David T. Rigdon, both pediatricians, are the only board-certified geneticists in the Air Force.

MLA Offers Free Asthma Handbook

Jackson, MS - "The Asthma Handbook" is a self-help booklet that answers questions asthma patients ask. The 28-page booklet tells about asthma triggers, asthma medicines, how to control episodes, and how to head off oncoming breathlessness. For a free copy, contact the Mississippi Lung Association, P. O. Box 9865, Jackson, MS 39206.

MD Disciplinary Action Information

Chicago, IL - Medical licensure boards will be notified by the AMA when a physician loses his license for incompetence, the association told the Senate's Special Committee on Aging. Using the AMA Physician Masterfile, the AMA will send information on a disciplinary action in one state to all other states where the physician has held a license.

Practice Management Courses Available

Chicago, IL - Study courses for physicians and their medical staffs are available from the AMA. The audiocassette and videocassette courses are: "Developing a Marketing Plan for Your Medical Practice," "Handling Patient Telephone Calls Effectively," and "Medical Collections." To rent or purchase the courses, call the AMA tollfree at 1-800-621-8335.

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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

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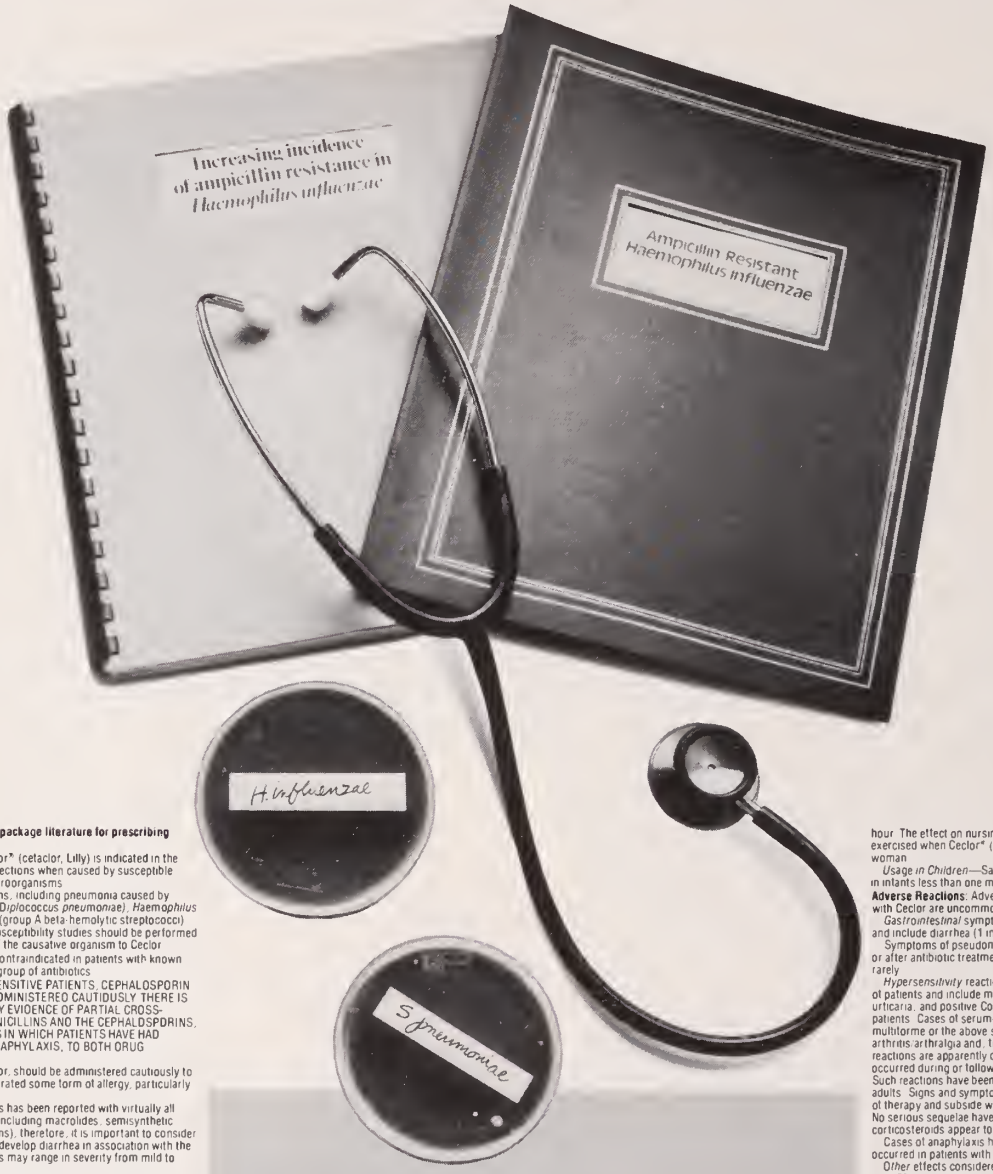
An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[0617B2R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae* *

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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ORIGINAL PAPERS

Arthroscopy — A Review of 220 Cases

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Arthroscopy is rapidly becoming one of the most common orthopaedic surgical procedures, notes the author, who reports a review of 220 arthroscopic procedures. He discusses advantages of the procedure, including shorter hospital time, less postoperative pain, and a shorter rehabilitation time.

OVER THE PAST DECADE, arthroscopic examination of the knee joint has become one of the most common orthopaedic surgical procedures performed. Reduction of hospitalizaton, pain, and expense, along with excellent visualization of the interior of the knee joint have accounted for its explosive popularity.

The first accounts of arthroscopy were by Takagi[1] of Tokyo, Japan. In 1918 he reported visualizing a tuberculous cadaver knee with a cystoscope and was astounded by the clarity and detail he was able to demonstrate. The modern era of arthroscopy was introduced by another Japanese surgeon, Watanabe, with his 1959 introduction of *The Number 21 Arthroscope*.[2] In the mid 1960's, Robert Jackson of Toronto, Canada was the first surgeon to bring arthroscopy to the North American continent. In 1970, he presented his results of 200 cases[3] describing his diagnostic accuracy using the arthroscope.

During the decade of the 1970's there was a spectacular rise in popularity of arthroscopy. With the perfection of diagnostic techniques, use of the arthroscope became more accurate, especially in the diagnosis of acute knee injuries. These techniques have led to the development of arthroscopic surgical instruments which allow the surgeon to perform many surgical procedures which previously required arthrotomy.

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Technique

Arthroscopic surgery requires an investment in specialized equipment including a fiberoptic light source, a fiberoptic arthroscope, a television camera monitor and recorder, and a small surgical probe. Surgical instruments such as specialized knives, basket forceps, scissors, and power trimmers are necessary if surgical arthroscopy is to be performed.

Arthroscopy is carried out under sterile conditions in the operating room, usually under a general anesthetic. In some cases local anesthesia can be used. An inflow cannula is placed into the joint, and the knee is distended with saline. The standard portals of entry for the arthroscope are anterior medial and anterior lateral just below the patella and adjacent to the patella tendon. Through these two portals approximately 90% of all knees can be thoroughly examined and the structures probed with a surgical probe. Occasionally, a posterior medial or posterior lateral puncture is required to visualize structures in

back of the knee. Additional punctures may be required to complete arthroscopic surgical procedures, as for meniscectomy. After the procedure is completed, the puncture wounds are closed and a compression dressing is applied.

Materials and Methods

Over a 36 month period, 220 consecutive arthroscopic cases were performed. The average age was 36 years, and there were 137 males and 83 females in the group.

The primary diagnoses established during these arthroscopic procedures are outlined in Table I. Torn meniscii accounted for the majority of the cases. Degenerative arthritis, pathological synovial plicae, chondromalacia of the patella, loose bodies, and torn anterior cruciate ligament accounted for the bulk of the remaining cases. Of interest is one patient with a postoperative infection of a total knee arthroplasty in which the diagnosis was established by arthroscopy and synovial biopsy under arthroscopic control.

Of the 220 cases, 167 required arthroscopic surgical procedures (see Table II). Again, meniscectomy or partial meniscectomy was the prevailing procedure performed. This was followed by articular shaving, removal of loose bodies and excision of plicae.

An additional 24 patients required open operative procedures once the diagnosis had been established by arthroscopy. The bulk of these arthrotomies were for repair of torn meniscii or ligaments.

Twenty-nine patients required only conservative treatment after the diagnosis was made by arthroscopy. These cases consisted mainly of patients with small capsular tears or torn anterior cruciate ligaments in which no clinical instability could be demonstrated.

Postoperatively, the majority of patients were allowed to be up and experiencing partial weight bearing the afternoon following surgery. Crutches were used for a week in order to allow the knee to rest and facilitate healing. Compression dressings and isometric exercises were used.

Results

Of the 220 cases, most were done as inpatients. The average hospital stay was 1.7 days. During the series, as our arthroscopy team became more comfortable with the procedure, many patients were done as outpatients and the average hospitalization steadily decreased. There were no deep infections, and pain was controlled with oral analgesics in most patients.

The majority of patients recovered very quickly from the arthroscopy; the average back to work time in our group was 2.5 weeks from the day of surgery.

TABLE I

PRIMARY DIAGNOSES

A. Meniscal tear	108
B. Degenerative arthritis	26
C. Synovial plica	19
D. Chondromalacia patella	17
E. Loose body	16
F. Torn anterior cruciate ligament	12
G. Synovitis	7
H. Subluxation/dislocation patella	7
I. Normal knee	5
J. Capsular tear	2
K. Infection total knee	1

TABLE II

I. Arthroscopic surgical procedures		167
A. Meniscectomy	97	
B. Articular shaving	31	
C. Removal loose body	16	
D. Excision plica	13	
E. Lateral retinacular release	9	
F. Synovectomy	1	
II. Arthrotomy procedures		24
III. Conservative treatment		29

Conclusions

Arthroscopy is a safe and reliable way to examine a knee joint. Many surgical procedures which once required arthrotomy can now be done with the use of the arthroscope. Infection rate in arthroscopy is very low. Hospitalization time is reduced greatly, thus decreasing medical expenses. Rehabilitation time is greatly decreased, facilitating return to work and thereby again decreasing medical costs. ★★★

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Malignant Fibrous Histiocytoma Associated with Diverticulitis of the Colon

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MALIGNANT FIBROUS HISTIOCYTOMA (MFH) is the most common sarcoma of old age,[1] MFH usually presents as a mass in the lower extremity and metastases are most frequently to the lung. We report a case of MFH which presented as an isolated metastasis to the sigmoid colon associated with diverticulitis. Isolated tumor metastasis to the colon is unusual. The most frequent tumors that metastasize to the colon are from the ovary, breast, pancreas, and stomach.[2]

Case Report

The patient, an 85-year-old white male, was admitted to the Biloxi Regional Medical Center in January of 1981 with a two day history of fever and left lower quadrant abdominal pain. Examination revealed an acutely ill white male with a fever of 103°. There was abdominal tenderness to palpation in both lower quadrants with rebound and decreased bowel sounds. CBC revealed a hemoglobin of 14 grams% and a WBC of 23,000. Chest x-ray was normal. He was taken to surgery and found to have diverticulitis of the colon with perforation of the sigmoid colon and small bowel obstruction secondary to severe inflammatory reaction. Right transverse colostomy with pelvic drainage was performed. The patient's postoperative course was essentially uncomplicated and he responded well to antibiotics. In May 1981, he underwent colostomy closure and left colectomy. At this time examination of the remainder of the abdomen was normal, as were the CBC, SMA-18, and PA and lateral x-ray of the chest. The pathological specimen revealed a portion of the sigmoid and descending colon with multiple diverticula. There were several small 5 mm white nodules on the serosal surface of the sigmoid colon over the tip of the diverticulum that had perforated. These nodules were malignant fibrous histiocytoma.

In 1977, a right radical inguinal orchiectomy and suprapubic prostatectomy was performed for a MFH of the right spermatic cord.

In March 1983, the patient underwent complete evaluation because of upper abdominal pain. Physical examination revealed an elderly white man who appeared to be well-nourished and well-hydrated. No lymphadenopathy or masses were noted. The heart and lungs were normal. The abdomen showed healed surgical scar with no organomegaly or masses detected. The scrotum revealed absence of the right testicle. CBC, SMA-18, urinalysis, chest x-ray and CT-scan of the abdomen were normal. Upper GI series showed a hiatal hernia. Barium enema showed diverticula and surgical absence of the left colon.

Discussion

Malignant fibrous histiocytoma (MFH) is the most common soft tissue sarcoma of late adult life. Weiss and Enzinger analyzed 200 cases of MFH and found a peak incidence of 50-70 years of age.[1] A mass in the abdominal or retroperitoneal cavity was the presenting sign in 16% of patients with MFH, whereas the remaining patients presented with a mass in the extremities. The local recurrence rate of MFH is 44% and distant metastases are detected in 42% of patients. Metastases are to the lung in 80%, to the lymph nodes in 32% and to the liver and bone in 15% of patients with MFH. Approximately 10% of patients with MFH have metastases to the mesentery of the bowel although the remaining gastrointestinal tract is usually not involved. MFH has a two year survival rate of 60%. In the 167 cases of MFH reported by Kearney, 29 patients had metastases to organs other than the lungs.[3] Multiple intraperitoneal metastases were seen in five patients and

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included the liver, peritoneum, pancreas, spleen, colon, small bowel, and omentum. Solitary gastrointestinal metastasis from MFH is extremely unusual but has recently been reported in the stomach.[4]

Isolated metastatic tumors of the colon are rare and generally present as obstruction. Brown reported a patient with sigmoid colon obstruction due to metastasis from a primary bronchogenic carcinoma.[5] Schouten reported a patient with descending colon obstruction due to metastasis from a fallopian tube carcinoma.[6] In an interesting patient reported by Weisberg, metastatic adenocarcinoma of the breast masqueraded as Crohn's disease of the colon.[7]

Ginaldi presented the radiographic observations in 45 patients with serosal metastatic implants of the colon.[2] Serosal metastatic implants cause a characteristic thethering of the colon wall. Ginaldi states these implants present as folds that do not completely transverse the lumen of the colon. He has described this radiographic appearance as the "striped colon." Colon metastasis can also present radiographically as an indention, angulation, narrowing, displacement, fixation, and serosal plaque.

The patient reported is interesting because he presented in 1977 with an MFH of the right spermatic cord and had an isolated metastasis to the colon in 1981. In 1983, he was re-evaluated because of abdominal pain but no recurrence of his MFH was detected. We believe this is the first reported case of an isolated metastasis from MFH presenting as diverticulitis.

Diverticulosis of the colon is commonly seen in the older patient. Diverticula are formed by herniation of the mucosa through the submucosa to the serosa of the colon. Diverticula are common in the sigmoid where the colon is narrowest and where there is an increased intraluminal pressure. Since MFH presents as a serosal metastasis, this may have precipitated the perforation of the underlying diverticula with a subsequent abscess formation. There is no direct blood flow or lymphatic drainage from the right spermatic cord or testis that would explain the isolated sigmoid metastasis in this patient.

When evaluating patients with diverticulitis, associated tumor must be excluded. A barium enema examination is frequently performed which may show diverticular abscess, but the radiologist frequently cannot exclude a perforated cancer associated with diverticulosis. Schnyder reported a double blind study of the radiographic accuracy in diverticulitis, diverticulosis, and carcinoma of the colon.[8] They reviewed the barium enema studies in 73 patients with diverticular disease of the colon with or without associated neoplasm. They concluded that the correct radiographic recognition of an associated neoplasm in a colon with diverticulitis or diverticulosis can only be made 55% of the time. This poor diagnostic accuracy was made in patients with colon cancer, which is a mucosal disease in contrast to metastatic disease, which is frequently to the serosa. Colonoscopy is usually not helpful in that it is contraindicated in diverticulitis. Since MFH metastasizes to the serosa, diagnosis would be extremely difficult preoperatively. ★★★

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Adenoid Cystic Pattern in Uterine Cervical Carcinoma: Report of Three Cases

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Laurel, Mississippi

ADENOID CYSTIC CARCINOMA is usually seen in salivary glands, lacrimal glands, skin, upper gastrointestinal tract, respiratory systems and breast.[7, 15, 16, 17, 18] In the uterine cervix it is an uncommon occurrency.

Bilroth in 1856[1] first utilized the term cylindroma (Kylindros, tubules, oma, tumor) to describe tumors of the head and neck, composed of cellular and hyalinized stromal cylinders, and considered the cellular cylinders to be granular canaliculi arising from lacrimal glands and the hyaline cylinders to be malformations of the connective tissue. Since that time numerous reports have appeared in the medical literature describing this tumor type in various organs, especially those of head, neck and breast.[5, 7, 18, 21, 22]

In 1949 Paalman and Couseller[2] first reported an adenoid cystic carcinoma of uterine cervix, and it was not until 1962 that the next report appeared in the literature by Tchertkoff and Sedlis,[3] followed by two other reports in 1964 and 1969.[10, 23] And it was not until 1972 that the first study of the ultrastructure of adenoid cystic carcinoma of cervix was reported,[24] followed by a report of three cases in 1977.[25]

Clinical Histories

Case I was a 70-year-old black female, para 3 grava 3, who had been in fairly good health until she developed a bloody vaginal discharge. Biopsy revealed a poorly differentiated carcinoma with adenoid cystic pattern. The patient was treated with irradiation therapy. Eight months later she was found to have a large cervical tumor without evidence of metastatic disease outside the pelvis. The patient underwent pelvic exenteration. The patient died eight days postoperatively due to pulmonary emboli. No autopsy was performed.

Case II was a 66-year-old white female, para 4 grava 4, who was lost to follow-up after the cervical biopsy and diagnosis were made.

Case III was a 69-year-old black female, para 2 grava 4, with a history of vaginal spotting. Her last menstrual period was 18 years previously. Pelvic examination revealed a protruding tumor from the cervical os. Biopsy revealed cervical carcinoma with adenoid cystic pattern and focal squamous differentiation. She underwent a hysterectomy with bilateral salpingo-oophorectomy, followed by radiation therapy five months later, in her country of origin. No follow-up was available.

Material and Methods

Tissue from each tumor was processed by routine formalin fixation and embedding in paraffin. The paraffin sections were stained with hematoxylin and eosin, alcian blue, P.A.S., and congo red stain. Some fresh tissue from case I was also fixed in 2.0% glutaraldehyde, postfixed in 1% osmium tetroxide in 0.1 m sodium cacodylate buffer. The tissue was then dehydrated using graded acetone solutions. Ultramicrotome sections were stained with uranyl acetate and lead citrate.

Gross Pathology

The surgical specimen of Case I demonstrated an ulcerated tumor mass, friable and necrotic, that arose at the squamous columnal junction and replaced the cervix and obliterated the endocervical canal. The cut surface was necrotic, friable and bloody with a grayish color.

Case II yielded a biopsy specimen that measured 0.4 x 0.3 x 0.3 cms from a tumor that protruded from the cervical os and grossly appeared soft, necrotic, friable and bloody.

Case III consisted of a cervical biopsy of a large tumorous growth that extended into the vaginal for-

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nices, and appeared necrotic, friable and bled easily. The specimen measured 0.6 x 0.5 x 0.6 cms.

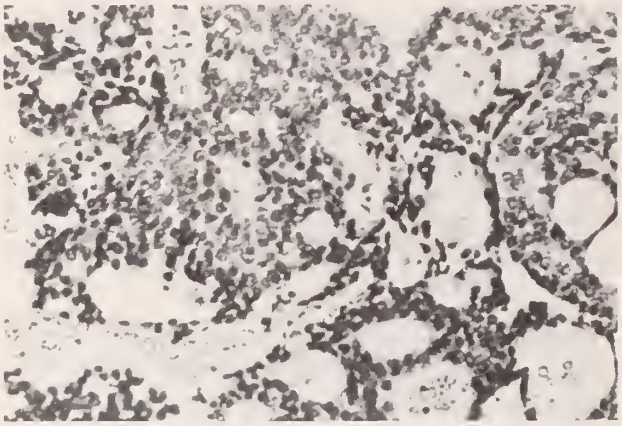

Figure 1. Characteristic adenoid cystic pattern in cervical carcinoma.

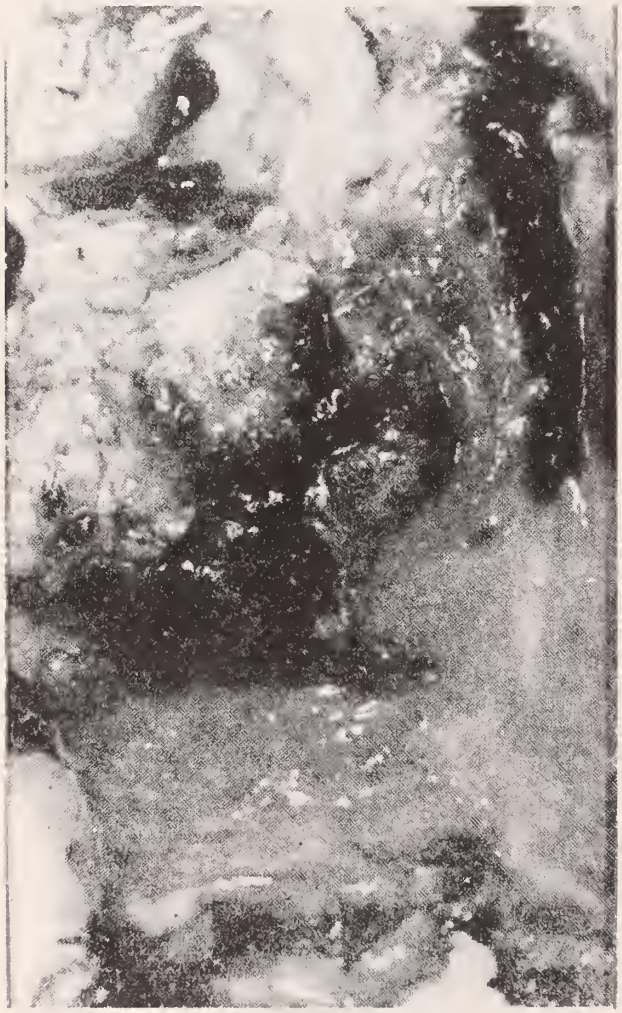

Figure 2. Large adenoid cystic tumor in cervix.

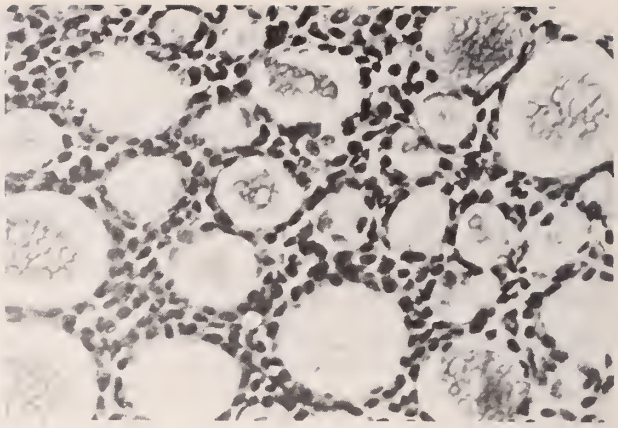

Figure 3. Characteristic adenoid cystic pattern in cervical carcinoma.

Light Microscopy

The three neoplasms shared similar histopathologic features with a variable but dominant adenoid cystic pattern composed of sheets, broad strands and nodules of basaloid, fairly uniform cells with vesicular nuclei and scanty, ill-defined, pale staining cytoplasm. Within these areas there were cystic gland-like spaces lined with cuboidal type cells. The gland-like lumens was filled with amorphous eosinophilic material that was periodic acid schiff positive, congo red negative and questionable alcian blue positive. There also were foci suggestive of squamous cell differentiation, in all three cases.

Electron Microscopy

The most significant finding was the suggestion of two types of cell population. One cell type revealed pleomorphic nucleic, varying amount of glycogen in the cytoplasm, and poorly developed, infrequent desmosomes. The other cell types were rather well differentiated with well formed desmosomes. Both cell types were surrounded by distinct basement membrane. The cystic spaces contained electron dense material.

Discussion

Adenoid cystic carcinoma of the head and neck region is not a rare neoplasm and was first described by Bilroth in 1856.[1] In contrast, uterine cervical carcinoma with adenoid cystic pattern is uncommon and was first described in 1949[2] and followed by a report in 1962.[3]

In the three cases reported in this study as in others there was some variability in the pattern among the tumors, but they had in common the characteristic

adenoid cystic pattern composed of small cells with sparse cytoplasm arranged around cystic gland-like lumina.

The multiplicity of differentiation present in these tumors has been previously noted, suggesting a range of differentiation in the same tumor. Miles and Norris,[13] as well as Moss and Collins[23] and Singleton et al,[25] reported squamous cell carcinoma and adenocarcinoma merging with adenoid cystic carcinoma of cervix. From the information gained from review of the literature and this study, the following conclusions may be stated:

(1) Uterine cervical carcinoma with adenoid cystic pattern is a distinct entity;

(2) The cervix is partly derived from entoderm of the urogenital sinus,[15, 20] and is also ectodermal in origin,[4, 20] with potential for squamous and glandular differentiation. Thus, one may accept the occurrence of entodermal and ectodermal associated neoplasia arising in the uterine cervix;

(3) The biological behavior of these tumors would be at least as aggressive as their counterparts of the head and neck region.

(4) The various modalities of therapy will benefit from more follow-up and case reports. ★★★

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Journal policy prohibits publication of more than ten references. For a complete bibliography, please contact the author.

Radiological Seminar CCXXXIX: Solitary Thyroid Nodule Rationality of Diagnostic Tests

BHARTI R. PATEL, M.D.
Jackson, Mississippi

SOLITARY THYROID NODULE is a term generally used for a thyroid nodule which is palpable on physical examination. The following pathologic process should be considered in the differential diagnosis.

1. Thyroid adenoma
   a. functioning
   b. non-functioning
2. Primary thyroid malignancy
3. Thyroglossal duct cyst
4. Metastatic lesion in thyroid
5. Normal thyroid tissue (anatomic variant)
6. Lymph node
7. Extrinsic mass (e.g., parathyroid adenoma)
8. Focal thyroiditis
9. Abscess

Radionuclide iodine scintiscan plays a useful role in evaluation of the solitary palpable thyroid nodule. Though it does not serve as an absolute criterion in differentiating thyroid cancer vs. benign thyroid pathology in the palpable nodule, it is very useful in determining the probability of cancer in a solitary thyroid nodule.

It is convenient to subdivide solitary thyroid nodules, on scintiscan, into three main categories: cold, warm, and hot.

"Cold" Nodule

A cold nodule (see Figure 1) shows either no uptake or markedly decreased uptake compared to the surrounding thyroid. A cold nodule represents nonfunctioning or hypofunctioning nodule. The pathologic processes to be considered in the differential diagnosis in a cold nodule are:

Common

1. Non-functioning adenoma
   a. solid
   b. mixed (solid and cystic)
2. Cancer
   a. solid (usually)
   b. mixed (rarely)

Uncommon

3. Thyroglossal duct cyst
4. Abscess
5. Focal thyroiditis
6. Parathyroid adenoma
7. Lymph node
8. Metastatic lesion

Approximately 70% of the solitary cold nodules are thyroid adenomas. The general incidence of thyroid cancer is thought to be about 15-20% in patients with a solitary cold nodule and without any prior history of radiation to the head and neck. In the presence of prior history of radiation, the incidence of cancer rises up to approximately 25-30% in a solitary cold nodule.

Ultrasound examination is very sensitive in detecting solid or mixed appearance vs. purely cystic nature of the nodule. Commonly cancer has a solid appearance and adenomas can be either solid or mixed. Purely cystic nature of the nodule is seen in thyroglossal duct cyst. While ultrasound cannot differentiate between benign and malignant nodules, it is helpful in determining the probability of malignancy in a solitary cold nodule. Parathyroid adenoma larger than 1 cm in size may give a scintiscan finding of a cold nodule, but can be diagnosed correctly on ultrasound.

Thyroid cancer has a solid appearance on ultrasound in the majority of patients. Occasionally a malignant lesion will show a mixed appearance on

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center, Jackson, MS.

Figure 1. Thyroid scan showing "cold" nodule in left lobe.

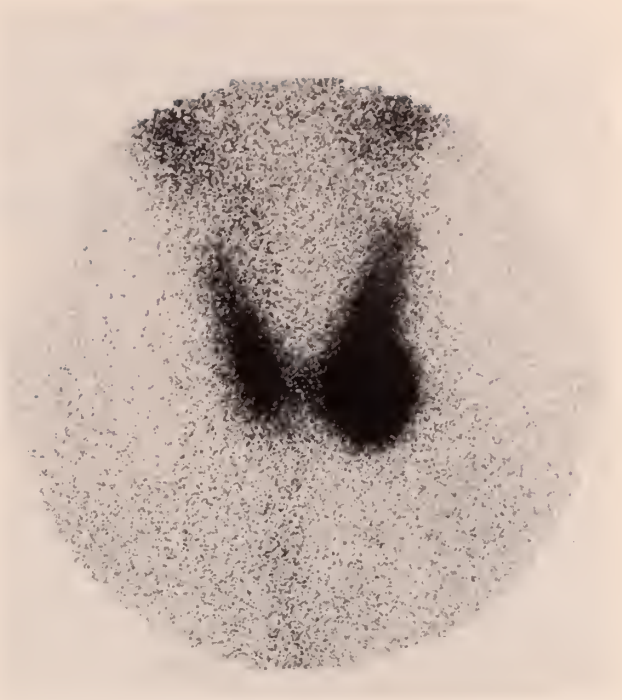


Figure 2. Thyroid scan showing "hot" nodule in left lobe.

ultrasound. Generally, a patient with a "cold" nodule on scintiscan and solid or mixed appearance on ultrasound should be a candidate for needle biopsy. Ultrasound examination can also be helpful in doing needle biopsy. Since the cellular material has greater diagnostic value compared to fluid from the cystic component in a mixed nodule, ultrasound of thyroid can be utilized for directing the needle to solid component during needle biopsy. The patient with adenoma can be managed by simple lumpectomy. However, a patient with thyroid cancer will require radical thyroid surgery. Thyroglossal duct cyst is easily recognized on ultrasound study. Excision of the cyst is necessary. Repeated drainage of the thyroglossal duct cyst is utilized for management if surgery is not possible or not desired by the patient.

"Hot" Nodule

A hot nodule (see Figure 2) is a palpable nodule showing activity greater than the surrounding thyroid gland on radioiodine scan. A hot nodule represents functioning thyroid tissue.

Major considerations in the differential diagnosis of such a lesion include:

1. Autonomous thyroid nodule
   a. toxic
   b. non-toxic
2. Anatomical variant of normal thyroid tissue
3. Hyperfunctioning tissue in a focal area secondary to thyroiditis or radiation.

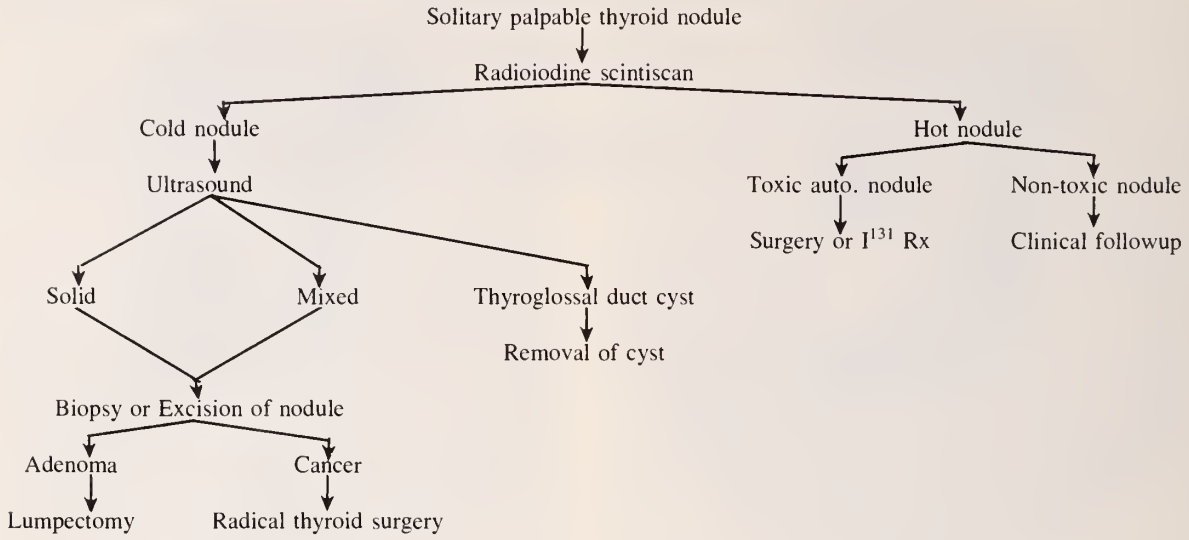
Other Nodules

"Warm" nodule: It is considered as a variant of hot nodule.

Autonomous nodule: An autonomous thyroid nodule can be toxic or nontoxic. When the autonomous nodule results in hyperthyroidism, it is called toxic autonomous nodule. An autonomous nodule is almost always benign and does not require needle biopsy.

Nontoxic Autonomous Nodule: Autonomous nodule does not necessarily result in a hyperthyroid condition. A Solitary hot nodule is noted on scintiscan in autonomous nodule. A repeat radioiodine scan following thyroid suppression for ten days with T_3 will show failure of suppression of activity in the nodule, while surrounding normal thyroid tissue is suppressed. T_3 suppression test can be performed if clinically indicated.

FLOW CHART IN EVALUATION OF SOLITARY PALPABLE THYROID NODULE



Toxic Autonomous Nodule: An autonomous toxic nodule will usually demonstrate suppression of the remaining thyroid gland to a varying degree, depending on the level of thyroid toxicity. The hyperthyroid state of a patient is usually confirmed by increased serum T_4, and serum T_3 value in combination with decreased serum TSH value in addition to clinical exam of the patient. Six hour and 24 hour radioactive iodine values are above normal in such patients. If desired, the suppressed thyroid gland can be stimulated by T.S.H. to be certain about the presence of normal thyroid tissue. Ultrasound examination of the thyroid gland can demonstrate anatomical presence of suppressed thyroid tissue.

Anatomical Variant: Occasionally normal thyroid tissue can be present anywhere along the line of descent during fetal life. A unilateral lobe is one of the anatomic variants. A unilateral lobe will usually be palpable and on scintiscan can be mistaken for autonomous nodule with complete suppression of the opposite lobe. Ultrasound study can offer help in visualizing the suppressed thyroid lobe and thus can differentiate between the presence of unilateral lobe vs. autonomous nodule with complete suppression of the opposite lobe.

Thyroiditis (focal): There is no definite appearance of thyroiditis on scintiscan.

Summary

In conclusion, scintiscan is very helpful in the evaluation of a solitary thyroid nodule and predicting the probability of cancer in a nodule but does not provide all the information needed in all the patients; thus ultrasound study of the thyroid gland should be obtained if indicated for further evaluation. Scintiscan and ultrasound of the thyroid have a complementary role in the evaluation of the solitary thyroid nodule. ★★★

2500 North State Street (39216)

SPECIAL ARTICLE

Address of the President

WHITMAN B. JOHNSON, JR., M.D.
Clarksdale, Mississippi

IN THE PAST YEAR, throughout most of the state, we have discussed the storm clouds over the sea of medicine. Some of these clouds have receded; others have rained on us and blown out their fury. Still others are on the horizon, and we as the crew, must prepare the ship to meet their force so we won't be hit broadside and be inundated or capsize.

Some of our former allies are no longer with us because of the cost of medical care or because of their own profit motive. Business, industry and insurance, instead of aiding or paying for medical care, are now entering the medical care field as "for profit" competitors for patients.

During the 1960's this nation was in the longest era of prosperity in its history; everything for everybody seemed possible and the cry was for increased services and technology. The 1970's were filled with oil and energy crises, a slowing of the economy, and spiraling inflation. Now, the reality of the 1980's is upon us, and it is apparent to all that everything is not possible for everyone. Even the federal government is on the verge of admitting that it can't replace God.

In 1965, with the passage of Medicare and Medicaid, a shift in the control of quality medical care occurred. The medical profession lost its grip. In 1968, in Nashville, Tennessee, two physicians named Frist and a patient named Jack Massey (one of Kentucky Fried Chicken founders) formed the hospital Corporation of America, which now controls some 400 hospitals. About the same time in Louisville, Kentucky, Humana Corporation was formed by two men with $4 million capital. Last year Humana had revenues of $1,516 million.

There are now 500 Wall Street-listed corporations involved in competition for the health care dollar. They have 10 million Americans working for them. Today, health care is the number one industry in the United States. With these profit-motivated businesses so heavily involved, quality is bound to suffer when profits decline because of government alphabet soup such as DRGs.

Future of Medicine

In a February meeting of physician leaders in the health care management field, several conclusions on the future of medicine were reached. First, 30-70% of Americans will be enrolled in some kind of prepayment health plan by 1994 unless there is a program of national health insurance. Secondly, PPOs are in the immediate future for medicine, HMO's in the middle run, and a composite of HMOs and PPOs or HCOs (Hybrid Care Organizations), in the distant future.

Third, an increasing part of the monetary risk in health care will be assumed by physicians. Fourth, physicians will become more cost conscious and move back into a closer relationship to hospital costs and administration as staff privileges become more dependent on DRG performance. And finally, if hospitals and physicians are given one DRG payment to divide, as proposed by some, it will cause a tremendous strain on their relationships.

A system of DRGs with prospective payment is not compatible with holistic medicine. It puts physicians in the position of treating a diagnosis rather than the patient as a whole. This will probably be misunderstood by our patients. Thus, our rapport with patients could be further undermined and our liability increased, while our reimbursement is decreased.

Still, we must cooperate with the hospital DRG effort and become more cost conscious, or face more onerous plans. One such plan called the Kennedy-Gebhardt bill would either extend DRG payment to

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President, Mississippi State Medical Association, 1983-84. Read before the House of Delegates, 116th Annual Session, May 17, 1984, in Biloxi, Mississippi.

all physicians' services and third party payors, or have state rate-setting programs as an alternative.

In the field of technology, it has been estimated that the market for microprocessing technology is 38% of the world's present economy. It has also been predicted that from 50 to 75% of all United States factory workers could be replaced by smart robots by the turn of the century. Already, in one center, a robot with a laser attached is reported to have done delicate brain surgery more accurately than a neurosurgeon. In that same center similar robots are ready to displace the orthopod in certain knee operations.

In the field of manpower, the latest statistics say that there are now 550,000 physicians in the United States. If this isn't enough competition, then add the JCAH, FTC, TLA (or Trial Lawyers Association) to the alphabet soup, then stir in the allied health professions, who are demanding hospital staff positions. Nurses are expecting admitting privileges soon in some states, and all are gaining momentum in our consumer, antitrust, plaintiff-oriented legal climate.

Malpractice Situation

While all of these problems will increase our malpractice danger, other factors must also be considered. To quote John Nesbitt, "Lawyers are like beavers; they get in the mainstream and dam it up." They also keep multiplying like beavers. In 1960, there were 250,000 lawyers in the United States; in 1983, 622,000 and by 1987, the total will reach 750,000.

Although it is easy to blame the malpractice problem on our over-populated legal profession, I'm afraid we must look inward to see the major cause. Quality of medical care is no longer a real issue for any honest physician. The poorest of us now practice better than the best were able to do 20 years ago with new technologies and their general application. Now, sometimes inadvertently without thinking, sometimes due to pressures, and possibly sometimes even due to professional jealously or competition, some of us are guilty of degrading others' efforts; while many of us can't or don't spend the time to get close to our patients to convince them that we are their friends or to let them see how hard we work to achieve the maximum result. MSMA's Communi-Care program is a help, but generally friends don't sue friends. Today the problem is not quality care but rather the patient's perception of quality care. If we can't work together to get this point across, there may be more truth than jest in the bumper sticker that extolled, "Support your local lawyer, send your child to medical school."

Medical Care Costs

As everyone knows, 10.5% of our gross national product goes for health care. According to a study published recently in the *Memphis Commercial Appeal,* one out of nine workers in that city are employed somehow in delivering health care. If these statistics were expanded nationally, and if the increase in longevity of five years and the decrease by one-half of the infant mortality were considered, then 10.5% seems somewhat low. As a comparison of increases in health costs over a six-year period in the 1970s, with countries having socialized medicine, their increases averaged from 18.2% in the United Kingdom to 20.5% in Australia; while the increase in the United States was 12.5%.

Since medical cost and competition are going to be continuing burning issues, and so we can continue to have control over quality and access, let us not get into the position of physicians in California and south Florida. The California Medical Association has a full time staff that does nothing but monitor the viability, honesty, quality, and stability of hundreds of PPOs, IPAs and HMOs which are constantly after the physicians, most of whom have to contract with multiple groups to stay in practice. In south Florida, the major employer-formed PPO involves 10 % of the work force and 400,000 people when dependents are included, leaving no physician input except compliance. Already some entrepreneurs have started to contract with hospitals and physicians in this state for services, and last week a group from Alabama was trying to solicit Mississippi physicians by mail. I would suggest — under these circumstances and under the imminent threat of having to collect combined payments from hospitals — that the MSMA Board of Trustees look into the feasibility of setting up a PPO and/or IPA to have a mechanism in place that can be activated should the necessity arise.

We at MSMA, realizing the importance of quality and cost issues, have increased our efforts in the field in areas that seem to be helpful to the membership. We have held practice management seminars for you and your assistants. For example, during the past year over 200 medical assistants have attended workshops on "Insurance Filing" and "CPT-4 Coding." More practice management workshops are planned for this year, which with

your suggestions can be structured to assist you in your individual practices.

We are also continuing our efforts to provide you with necessary services that will be cost competitive while realizing nondues revenues for the association, thus offsetting future dues increases. At this time, we are looking at data processing and central purchasing as two potential new sources. I urge you to be responsive to the surveys that will be made to determine your interest and needs in this regard.

Our MSMA headquarters in Jackson was constructed in 1956 and was last expanded and renovated in 1970. Our programs and continued constructive growth make necessary a building program, particularly as we look toward the future. The Board of Trustees has been studying this for some time, and has a report at this session for your attention.

Well, it seems that the storms of medicine will continue to rage. I can give and bend with the winds as well as the best of reeds, but my heritage is Mississippi, my love is medicine, and my home is the Delta where most of the farming used to be done with mules. Consequently I can agree with cost containment, strike out in bold new directions as suggested by the AMA, swallow the alphabet soup, although with some indigestion, and even live with all the competition. But when they push me to the point where quality of care or professional freedom come into danger, I am going to sit on my haunches and be as hard as a Mississippi mule to budge when he's been overworked in the dog days of summer. And I hope there will be some others there with me.

★★★

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MFMC and Peer Review Under PRO: What Changes Can You Expect?

PATSY SILVER

When the Mississippi Foundation for Medical Care (MFMC) was awarded the contract as the state's Professional Review Organization (PRO), a number of objectives were mandated. In a recent interview, MFMC medical director J. S. McIlwain, Jr., M.D., commented on those objectives. He described changes in the review process and outlined the Foundation's approach to implementing the new PRO system.

THE MISSISSIPPI FOUNDATION for Medical Care (MFMC) received notice June 29 of designation as the official Professional Review Organization (PRO) for Mississippi. The two-year contract with the Health Care Financing Administration (HCFA) became effective July 1.

Along with the contract came a set of specific objectives mandated by Congress when the PRO law was passed. Renewal of the contracts with physician-sponsored organizations such as the MFMC will depend upon the success of those organizations in meeting these objectives.

The PRO system, authorized by the Peer Review Improvement Act of 1982, replaced the ten-year-old Professional Standards Review Organization (PSRO) program. The law gave to the secretary of the Department of Health and Human Services the authority to contract with PROs for the purpose of promoting efficiency, economy and quality of health care services for which payment is made under the Medicare program. The statute also authorized state Medicaid agencies to contract with PROs for utilization review, and included a requirement that PROs make themselves available for private review on behalf of non-governmental third party payors.

Since the enactment of that law, there has been additional legislation which affects the operation of the PROs. That legislation, the 1983 amendment to the Social Security Act, produced the Medicare Prospective Payment System (PPS). The PPS system, which went into effect in October 1983, established a set of Diagnosis Related Groups and a prospective pricing system as a method to provide financial incentives to hospitals to hold down costs under Medicare. Up to that time hospitals were reimbursed on a "reasonable cost" basis.

Review Under PRO

The ultimate result is that the emphasis on peer review under PRO will be on hospital admissions, quality of care, DRG assignment, and outlier cases. And while the review process will be basically the same as under PSRO, it will now be more intensified. One immediate effect is that there will be more preadmission review.

Because the effective date of the contract came so soon after awarding of the contract, many specific actions have yet to be worked out, it was learned in an interview with MFMC spokesmen. The magnitude of the new responsibilities and the demands for results under PRO have made it necessary for the Foundation to recruit additional staff. There also has been the need to install new equipment such as an expanded telephone system for preadmission certification.

According to MFMC medical director J. S. McIlwain, Jr., M.D., the goal of the Foundation is not simply to meet the objectives, but also "facilitate the required changes in the least disruptive process possible to hospitals and physicians in Mississippi." There is a firm commitment on the part of the MFMC to maintain a leadership role in peer review, he commented.

In a recent letter to the 1,500 MFMC members, Dr. McIlwain reminded physicians of the stern attitude of the government, summarized by the statement of a United States senator that "This is the last chance for physicians to prove they can be accountable for cost effectiveness. The choice is not between peer review or nothing — if the physicians don't do it, an insurance company will."

The Foundation will continue to stress an educational, rather than punitive, approach, Dr. McIlwain declared. He discussed plans to develop a regular newsletter to keep physicians informed of developments, and he described plans to conduct meetings with medical staff and administrators at hospitals across the state. The Foundation is working closely with the Mississippi Hospital Association in implementing the changes, he added.

When queried about some physicians' fears that utilization review will extend into the private medi-

cal office, Dr. McIlwain commented that the best way to prevent extension into the office setting is to have good peer review now and demonstrate that physician control of the peer review process works.

Most physicians acknowledge the importance of having physician-directed peer review, Dr. McIlwain said. Beyond the obvious benefits of having physician direction, he added, there is an additional advantage. Since out-of-state review organizations (whether governmental or third party) would conduct review retrospectively, there would not be the cost savings that can be achieved with concurrent review by an in-state organization.

As the Mississippi Foundation for Medical Care phases in its required review processes, there may be some negative reaction to the new developments, Dr. McIlwain acknowledged. But he emphasized that the Foundation's goal will continue to be the maintaining of physician-directed review, and he appealed to state physicians to provide support and cooperation in achieving that goal.

One of the specific objectives outlined by the government is a 15,000 reduction in hospital admissions under Medicare. Mississippi must reduce admissions to meet national norms, Dr. McIlwain explained. The state now ranks third in the nation per 1,000 enrollees, and the HCFA expects the reduction to be accomplished. The demand will be for more hospital outpatient services, primarily.

Utilization Objectives

The specific objectives under the contract have detailed methodology and baseline data. The utilization objectives and the areas of health care delivery that they cover are summarized below.

Preadmission review. The objective here is to reduce Medicare admissions for specific procedures that could be performed effectively on an outpatient basis. They are: carpal tunnel release; unilateral repair inguinal hernia; D&C; pterygium excision NEC; hydrocele excision-spermatic cord; hydrocele excision — tunica vaginalis; circumcision; excision Morton's neuroma; small bowel endoscopy (EGD); biopsy of breast NEC; excision lesion tendon sheath hand; and cataract extractions.

Diagnosis Related Groups. The objective here is to reduce the number of inappropriate or unnecessary admissions for specific diagnosis related groups. They are: heart failure and shock; COPD; atherosclerosis; medical back problems; kidney and urinary tract disease; hypertension; specific cerebrovascular disorder except TIA; simple pneumonia and pleurisy; diabetes age equal to greater than 36; circulatory disorders with AMI without cardiovascular complications discharged alive; respiratory neoplasms.

Specific practitioners. The objective here is to reduce the number of inappropriate or unnecessary admissions or invasive procedures of 145 specific physicians; 22 physicians with high DRG weight factors per day of care; and all Mississippi practitioners not covered in the previous two groups.

Quality of Care Objectives

Among the objectives in the area of quality of care which are detailed in the new contract are:

1. *Reduce unnecessary readmissions resulting from substandard care provided during the previous admission*. This will be accomplished through education, strict review, lifting of waiver, or sanctions, as necessary.

2. *Assure necessary medical services* by reducing the incidence of AK or BK amputations on patients who did not have revascularization but were candidates for the procedure. This will be done through education, strict review, lifting of waiver, or sanctions, as necessary.

3. *Reduce avoidable deaths* by reducing the incidence of acute myocardial infarctions and postoperative complications. This will be done by education, and in cases of gross negligence, sanctions will be applied.

4. *Reduce unnecessary surgery or other invasive procedures* by reducing the number of unnecessary permanent pacemaker insertions and reimplantations; cardiac catheterizations; large bowel endoscopies; flexible fiberoptic colonoscopies; small bowel endoscopies; and transurethral prostatectomies.

5. *Reduce avoidable postoperative complications* by reducing the incidence of avoidable postoperative urinary infections from TUR prostatectomies. Interventions will be conducted as in Quality Objective number one.

Summary

A year ago, when the Peer Review Improvement Act was initiated, many physicians felt that the law reflected the confidence of Congress in the ability of physician-sponsored organizations to conduct peer review. While the new system imposes many demands on those organizations, Mississippi's official PRO, the Foundation for Medical Care, seeks to demonstrate that physician-directed peer review can be effective. According to Dr. McIlwain, the staff of MFMC remains receptive to suggestions for improving the peer review program and stands ready to offer assistance and information to Mississippi physicians. ★★★

The President Speaking

Medicine's Leaky Roof

Ellis M. Moffitt, M.D.
Jackson, Mississippi

I have borrowed some remarks alluding to the House of Medicine from the president's page of the *Journal of the Florida Medical Association*.

"The foundation of the House of Medicine is the local medical society, a strong, dedicated, independent, hardworking group of physicians. The walls represent the state medical societies. The roof, our national body, the AMA. The foundation and walls are in excellent shape, but the roof is 'leaky.' "

Just 73% of the members of MSMA belong to the AMA. But 100% of the members of the Illinois and Oklahoma medical associations belong to the AMA. However, nationwide only 45% of 500,000 physicians belong to the AMA. This has not severely impaired the effectiveness of the AMA in the legislative halls of Washington. As an example of this effectiveness, look at the recent Medicare mandatory assignment issue. But when you represent less than the majority it does impair your effectiveness to a degree. Think how much more could be accomplished with 100% membership. Leaders in Congress are aware of this representation.

The saddest part of this story is that no organization represents the majority of physicians. The AMA does represent the most, and no other medical organization approaches its total membership.

What this means is that 45% of physicians who are members of the AMA are supporting their other colleagues politically, socioeconomically, and to a large degree, academically. I would like to see 100% of our members become members of the AMA.

Only through the concerted efforts of every AMA member in our state and local medical societies contacting each non-member on a one-on-one basis can our goal of a unified membership be attained. I challenge each of you to start today on this job so we can look to a future that will leave a comfortable, secure, "non-leaking roof" for those who follow. Call our MSMA office today (1-800-682-6415-statewide WATS or 354-5433 in Jackson) and have a new AMA member signed up. ★★★

EDITORIALS

JOURNAL OF THE
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AUGUST 1984

Grin and *Bare* It (or Turn the Other Cheek)

How well I remember the comment by the gentleman representing PSRO at one of our annual meetings of the MFMC on the coast when he was asked by one of the audience if PSRO would enter our offices anytime soon. "No," says he, "Not in the foreseeable future." Please read the excerpt from a letter sent to me by one of our colleagues and I believe that you will agree that the "foreseeable future" is here now!

The Health Care Financing Administration requires that we conduct a postpayment review on a sample of physicians and suppliers. You were among the physicians chosen for review of 1982 services. Our review was directed primarily toward your injection and office laboratory services since your patients received these services more frequently than the patients of many physicians in your specialty group and area.

A sample of your claims was reviewed by our medical staff and consultant. This review indicated that the services mentioned above exceeded our guidelines for care reasonable and necessary to treat the patients' conditions. We did not find documentation on these claims to support services in excess of our guidelines. Therefore, an overpayment has been calculated based on the following:

Services	*Frequency*
Blood sugars	One per month
Hemoglobins	One every three months
Hematocrits	One every three months

We are continuing our study of your injection services, and we will advise you at a later date if an overpayment has been made.

The overpayment totals $5,496.08 and covers calendar year 1982. We request that you submit a check or money order for $5,496.08 made payable to The Travelers Insurance Company within 30 days of the date of this letter. After that date, future Medicare payments which may become payable to you are subject to being withheld, up to the amount of the overpayment, until this matter is resolved.

Effective September 3, 1982, Section 117 of the Tax Equity and Fiscal Responsibility Act of 1982 mandated the charging of interest on overpayments made to providers which are outstanding over 30 days subsequent to the final determination of an overpayment.

Now they can tell us who to treat; how to treat; what prescriptions for how many pills they will pay for; how much we can charge; and now how many of what tests we can order.

Do you feel the squeeze yet? Oh, woe is me . . . woe is me. I still thank God that I am a physician.

JOSEPH E. JOHNSTON, M.D.
Associate Editor

COMMENT

Hold Still

"Hold still! This won't hurt a bit." That is a familiar refrain in doctor's offices. It is usually heard just before some nurse who talks sweet and acts mean plunges a dagger of a needle into the buttocks of a poor, panicked human being. In most cases the therapeutic effect is worth the suffering because the medicine does some good in the long run. But if you're the patient, you never feel exactly the same about that nurse again.

Peer review is like that. All the talk you've heard (and may have come to believe, because it sounds so soothing) about helping with your record keeping, encouraging quality of care, honoring the privacy of the doctor-patient relationship and the friendly wink as we talk about containing cost is just leading up to a big shot.

Make no mistake, those guys who are paying the bills are thinking serious thoughts about cutting costs! They think that this system of ours is afflicted with a grave fiscal illness and that the only hope for cure is a painful injection of cost containment. The talk these days about competition in the market-

place, incentives, caps, alternative delivery systems, mandatory assignment, etc., is not just whistling Dixie. The people who are involved in the funding of health care have established a clear objective to get a handle on cost. This objective is supported by the public, by business and by political leaders.

Utilization review represents only one of several possible restraints on cost, but in a regulated system, utilization review is an inevitable requirement. In this environment, there is great potential for damage to the quality of health care and to the status of the profession of medicine.

One key for us in trying to prevent such damage is to maintain a leadership role for the profession even if we don't like the way the tide is running. Specifically, in the matter of peer review, only physicians can make the value judgments which will be required to minimize cost without compromising quality or impairing access to health care. Ideally, such judgments should be made by each individual physician in his own practice in response to his own recognition of the dangers which are inherent in a system which is too expensive and in response to the obligation which each of us has to our patients and to our profession. To the extent that physicians discipline themselves, they can avoid the external application of authority.

Those of us who have been active in peer review through the Mississippi Foundation for Medical Care fondly hope, as we move to implement our PRO contract, that our job will be made easier by the conscious, voluntary, and conscientious compliance of physicians with the economic constraints which confront the health care industry. Past experience suggests that most physicians will cooperate. Some won't. Realistically, the Mississippi Foundation for Medical Care must demonstrate effectiveness in utilization review, whether by persuasion or by coercion, if the prerogative to be reviewed by peers is to be retained by physicians. A great many politicians and bureaucrats hope that we fail so that someone else can move in. We will try to succeed, because the alternatives appear to us to be unpalatable and destructive. We need your participation and your support — and your forbearance.

In all honesty, this is going to hurt — but the medicine appears to be necessary, and the pain will probably be less if we hold still for it.

W. Lamar Weems, M.D.
Chairman, Board of Directors
Mississippi Foundation for Medical Care

LETTERS

To the Editor:

This letter is written concerning the advertisement of the UAB Multipurpose Arthritis Center in the State Medical *Journal*. We realize medical advertising is legal and unrestricted. Our concern is the precedent set by the *Journal*. We feel the advertisement is for patient population for financial reasons and not availability of medical and surgical services. The State Medical Society should represent leadership for the concern of its members. By accepting out-of-state appeals for patients, you challenge us to counter-respond by advertising our service. Although medical advertising appears to be upon us, we object to initiation by our state society.

Valee Harisdangkul, M.D.
Ken Hensarling, M.D.
Thomas E. Wilson, III, M.D.
Suthin Songcharoen, M.D.
Ann Myers, M.D.
R. Deaver Collins, Jr., M.D.
University Medical Center
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Jackson, MS 39216

To the Editor:

In the June 1984 edition of the *Journal of the Mississippi State Medical Association* Dr. John Evans presented "Mammography — Benefit and Risk," a timely article giving the background supporting mammography as a screening tool in the early detection of breast cancer. The Cancer-related Check-up Guidelines for breast cancer detection were modified for asymptomatic women age 40-49 years. Women in this age group should have a physical examination of the breasts annually, and mammography should be performed at intervals of 1-2 years. The other guidelines as presented in Dr. Evans' article are unchanged.

Sandra A. Rhoden, M.D.
1040 N. Flowood Drive
Jackson, MS 39216

To the Editor:

I would like to invite MSMA members' attention to the CHECK project promoted by the American Cancer Society. This project is an effort to reduce the nationwide mortality due to the second most

common malignancy in the USA: colorectal cancer. Previous studies targeted on subjects already followed in the health care system, have shown yearly hemoccult test of the stool to be a valuable instrument in diagnosing unsuspected colorectal cancer at an early stage. Combination of the yearly hemoccult test with proctoscopy every three years (after two negative yearly examinations) has resulted in an even greater diagnostic sensitivity. Early diagnosis is reasonably expected to be translated in an improved cure rate and increased survival. The goals of the CHECK project are:

1. To increase the awareness to the general population that colorectal cancer can be cured through secondary prevention.
2. To encourage every physician — both primary care physicians and specialists — to have these tests performed on all their patients who are 40 years old or older.

I feel that the initiative is highly worthwhile and deserves our cooperation and enthusiasm as professionals of the healing art.

I also would like to say that the CHECK project poses to all of us a special challenge. It is probably the first chance to join our forces in two rapidly growing and promising fields of medicine: public education and prevention. As the education level of our clients increases and as the epidemiological studies become sophisticated and more pressing, demand will be laid on our profession to act in the field of education and prevention. The CHECK program is one of our first chances to prove that as a group we have accepted this new reality.

Write the American Cancer Society (345 North Mart Plaza, Jackson, MS 39206) for information and material concerning the CHECK project.

I also would like for you to explore the need in your hospital for a program dealing with secondary prevention of colorectal cancer. The American Cancer Society will be happy to provide material and speakers for these local meetings.

Lodovico Balducci, M.D.
Chairman, Professional Education
Mississippi Division, American
Cancer Society

To Dr. Moffitt:

I am sending this letter to congratulate you on your inauguration to the presidency of the Mississippi State Medical Association. The staff and I at CADO Systems of Mississippi are very pleased you have been chosen to lead the Association this year.

Your inaugural address on the president's page in the *Journal of the Mississippi State Medical Association* is a well chosen theme for this year. The issues of practice cost controls, the increased competitive environment, and changing patient attitude toward what is expected from the medical profession are important issues to be addressed before "the year of physician" arrives.

We at CADO Systems of Mississippi and the computer industry in general who address the medical market are finding these issues of your profession as difficult and important to address as you are. Articles and editorials regarding the subject matter you covered influence more than just those directly in your profession. They influence those of us serving your industry who must provide products and services which allow the physician to compete and adapt in this changing environment.

As with most other businesses, the use of technology and automation is seen first and most often as a tool upon which to provide the line staff (those directly involved in producing the service or product) with the best methods of providing quality products and services in a cost efficient manner. The accounting and back office functions to many, however, do not seem to justify this same attitude towards quality and cost control that have been given to other parts of the business. This is where articles like yours and others are of great help in trying to show the physicians how automation in the back office can be part of an overall cost control program for the medical practice.

I know your term in office will be of great benefit to you and the Mississippi State Medical Association. Again, congratulations and much success.

Al Von Pingel, Systems Consultant
2600 Insurance Center Drive
Jackson, MS 39216

Journal MSMA welcomes your comments, suggestions, and inquiries. Please address your letters to: The Editors, P.O. Box 5229, Jackson, MS 39216.

CORRECTION: Dr. Martin Dalton of Jackson, pictured with Dr. Vann Craig and Dr. Jerry Adkins on page 198 of the July issue, was incorrectly identified. Dr. Dalton was named to the MSMA Surgery Planning Group for the 117th Annual Session. Dr. Ralph Abraham, not pictured, was elected secretary, Mississippi Chapter, American College of Surgeons.

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 16-20, 1985, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 117th Annual Session, May 15-19, 1985, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 25-29, 1985, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Pate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Secy., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Dan Jones, Secy., P.O. Box 2756, Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Delta Medical Center
P.O. Box 5247
Greenville, MS 38701

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

Oxford-Lafayette County Hospital
P.O. Box 946
Oxford, MS 38655

St. Dominic-Jackson Memorial Hospital
969 Lakeland Dr.
Jackson, MS 39216

Etheridge Receives MSMA Award for Medical Student Leadership

Jesse Chandler Ethridge of Madison, right, a 1984 graduate of the University of Mississippi School of Medicine, won this year's Mississippi State Medical Association Award in recognition of superior leadership qualities and scholarship. Ethridge received a $250 cash prize, and his name is engraved on a plaque permanently displayed at the Medical Center. Dr. Carl Evers, medical school associate dean for academic affairs and speaker of the MSMA house of delegates, presented the award to Ethridge during the 23rd annual honors convocation for the School of Medicine. Ethridge is the son of Dr. and Mrs. H. C. Ethridge of Madison.

UMC Awards Degrees to 378 Graduates

University of Mississippi chancellor Dr. R. Gerald Turner delivered the address for the 28th annual University of Mississippi Medical Center Commencement exercises in Jackson May 27.

He also awarded degrees to some 378 health sciences students. The total included 155 for the MD; 115 for the BS in nursing; 14 for the PhD, the MS, the MS in nursing, and the master of combined sciences; and 37 for the DMD.

Graduates also included two for the BS in cytotechnology, six for the BS in medical record administration; nine for the BS in medical technology; 12 for the BS in nurse anesthesiology; 23 for the BS in physical therapy; and five for the BS in respiratory therapy.

Top graduates recognized during the ceremonies were Allen Gafford Jones of New Albany, MD; Amy Mize Dudley of Jackson, BS in nursing; Robert Scott Gatewood of Raymond, DMD; and Rachel Ann Williams of Newton, BS in physical therapy.

Dr. Jones, the son of Mr. and Mrs. Willard M. Jones, received the Waller S. Leathers Award as the graduating medical student with the highest academic average for the four years of medical school. He received his degree summa cum laude. He earned the BA at the University of Mississippi in 1980 and will intern at North Carolina Memorial Hospital in Chapter Hill.

Ms. Dudley, daughter of Mrs. Blanche Dudley, received the Christine L. Oglevee Memorial Award. The recipient is selected by the dean and faculty as the outstanding nusring school graduate. She also received her degree summa cum laude.

Dr. Gatewood, son of Dr. and Mrs. Hiram Gatewood, received the Dean's Medal in Dentistry as the graduating dental student with the highest academic average for four years of study. Dr. Gatewood is a 1980 graduate of Mississippi College.

Ms. Williams, daughter of Mr. and Mrs. Ellis H. Williams, was selected by fellow students and faculty to receive the School of Health Related Professions Award as the most outstanding graduating student.

Other honor graduates in the School of Medicine included Richard Harold Flowers III of Greenwood, Thomas Albert Quigley III of Gulfport, and Russell Cary Linton of Columbus, all of whom earned their degrees magna cum laude; and Edward Rather Willis, Jr. of Clinton, Don W. Buckley of Jackson, Steven Rhodes Shields of Moss Point, Leta Teresa Callahan of Jackson, Charles William Deaton, Jr. of Booneville, and Stanley Lee Miller of Starkville, all receiving their degrees cum laude.

MSMA Award Honors Outstanding SHRP Graduate

Rachael Williams of Newton, center, who received the B.S. in physical therapy in University of Mississippi Medical Center 1984 Commencement ceremonies, was recognized as recipient of the Health Related Professions Award which goes to the student in the school who is deemed most outstanding by faculty and students. The award is sponsored by the Mississippi State Medical Association. Commencement principals included, from left, Dr. Carl Evers, medical school associate dean for academic affairs and speaker of the house of the delegates, MSMA, Dr. R. Gerald Turner, University of Mississippi chancellor, Dr. Thomas E. Freeland, dean of the School of Health Related Professions and Dr. Norman C. Nelson, vice chancellor for health affairs, UMC. Ms. Williams is the daughter of Mr. and Mrs. Ellis H. Williams of Newton.

MLA Honors Dr. Campbell

Dr. Guy D. Campbell, left, was recently honored by the American Lung Association for dedicated service as Mississippi Lung Association's Representative Director to the American Lung Association Board of Directors. Dr. G. Boyd Shaw, right, has been elected to serve as MLA's Representative Director for a three-year term. Both Dr. Campbell and Dr. Shaw are members of the Executive Committee and Board of Directors of the Mississippi Lung Association and both are former presidents of the Mississippi Thoracic Society.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

Aug. 18
OPHTHALMOLOGY UPDATE 1984
Holiday Inn Downtown, Jackson

Sept. 6
BULIMIA AND ANOREXIA NERVOSA
Holiday Inn North, Jackson

Oct. 4-5
FAMILY PRACTICE UPDATE
Jackson

Oct. 26-27
ANNUAL PEDIATRIC MEETING
University Medical Center, Jackson

For registration information and a brochure, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505. Phone (601) 987-4566.

NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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NEW MEMBERS

Abide, John Michael, Greenville. Born Greenville, MS, March 8, 1947; M.D., University of Mississippi School of Medicine, Jackson 1974; interned Baylor University Medical Center, Dallas, TX, one year; dermatology residency, University of Arkansas Medical School, Little Rock, 1976-79; chemosurgery fellowship, Emory University Medical School, Atlanta, GA, one year; elected by Delta Medical Society.

Adams, James Gray, Cleveland. Born Clarksdale, MS, Dec. 14, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; one-year family medicine internship, University Medical Center, Jackson; elected by Delta Medical Society.

Adams, Lawrence James, Greenville. Born Evanston, IL, Jan. 30, 1952; M.D., University of Illinois College of Medicine, Chicago, 1978; interned St. Francis Medical Center, Peoria, IL, one year; pathology residency, Methodist Medical Center, Peoria, 1979-83; elected by Delta Medical Society.

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Brooks, Sister Ann E., Tutwiler. Born Washington, DC, June 4, 1938; D.O., Michigan State University College of Osteopathic Medicine, East Lansing, 1982; interned Riverside Osteopathic Hospital, Trenton, MI, one year; elected by Clarksdale and Six Counties Medical Society.

Gore, Judith K., Jackson. Born Jackson, MS, Oct. 23, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family medicine residency, University Medical Center, Jackson, 1980-83; elected by Central Medical Society.

Marrerro, Elias A., Biloxi. Born San Juan, Puerto Rico, Feb. 6, 1936; M.D., Facultad de Medicina de la Universidad de Santiago de Compostela, Santiago de Compostela, Spain, 1961; interned two years, Susoni Hospital, Arecibo, Puerto Rico; elected by Coast Counties Medical Society.

McGehee, Ramon P., Jackson. Born McComb, MS, June 10, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and ob-gyn residency, University Medical Center, Jackson, 1975-79; fellowship, gynecology-oncology, M.D. Anderson Hospital, Houston, TX, 1979-81; elected by Central Medical Society.

McIntire, Leon L., Picayune. Born Lafayette, LA, Dec. 6, 1934; M.D., Tulane University School of Medicine, New Orleans, 1959; interned one year, Confederate Memorial Medical Center, Shreveport, LA; radiology residency, Charity Hospital, New Orleans, 1972-74; elected by Pearl River Medical Society.

Maurice Snyder, Meridian. Born Everett, WA, Jan. 9, 1928; M.D., University of Washington School of Medicine, Seattle, 1954; interned one year, United States Public Health Service, New Orleans; elected by East Mississippi Medical Society.

Sproles, Arthur C., Gulfport. Born New Orleans, LA, Jan. 13, 1946; M.D., Tulane University School of Medicine, New Orleans, 1970; interned and surgery residency, Charity Hospital, New Orleans, 1970-75; elected by Coast Counties Medical Society.

Timm, David Alan, Natchez. Born Michigan City, IN, April 12, 1955; M.D., Louisiana State University School of Medicine, New Orleans, 1981; interned and pediatric residency, Charity Hospital, New Orleans, 1981-84; elected by Homochitto Valley Medical Society.

PERSONALS

James Achord of UMC lectured at a meeting of the Alabama chapter of the American Academy of Family Physicians in Gulf Shores, Alabama.

O. J. Andy of UMC made presentations at the Pavlovian Society International meeting in Moscow, Russia, in June.

J. James Arfania announces the opening of his office for the practice of obstetrics and gynecology at 500 West Main Street in Fulton.

Bernard H. Booth of Jackson has been honored as boss of the year by LeFleur's Bluff Chapter of the American Business Women's Association.

Nate Brown announces the opening of the Mid-Delta Family Practice Clinic in Cleveland.

Richard E. Buckley announces the association of Harry A. Danielson for the practice of neurological surgery at Coastal Medical Center in Biloxi.

Stephen L. Conerly has associated with William H. Gullung of Hattiesburg for the practice of dermatology.

Larry H. Day of Hattiesburg was elected to fellowship in the American Society for Head and Neck Surgery.

John M. Dowbak announces the opening of his practice in orthopedic surgery at Magnolia Doctors Plaza, Suite 103, in Corinth.

Edgar Draper of UMC taught a workshop on spirituality in health care at the Salt Lake City Veterans Administration Medical Center in June and chaired the Committee on Religion and Psychiatry and a panel discussion at the annual meeting of the American Psychiatry Association in Los Angeles.

Claude E. Fox of Jackson, recently appointed as Mississippi's first deputy state health officer, has been named recipient of the 1984 Young Professional Award presented by the American Public Health Association's Maternal and Child Health Section.

Pat Gill of Macon spoke at the Clarke County Chapter of the Hospital Christian Fellowship, on the subject of medical missions work.

Catherine Goetz, retiring this year from UMC, recently received a special citation for her service to the institution.

Valee Harisdangkul of UMC made a presentation at the 48th Annual Meeting of the American Rheumatism Association in Minneapolis, Minnesota.

Harper Hellems of UMC participated in the presentation of a Paul Dudley White Award at the New England Heart Association meeting in Boston.

Richard M. Hilborn has associated with The Street Clinic in Vicksburg for the practice of orthopedics.

Lucien R. Hodges of Jackson has been named president of the Neurosurgical Society of America.

John Jackson of UMC recently was consultant to the Research and Development Division of the Louisiana Board of Regents in New Orleans and conducted a seminar at Meharry Medical College in Nashville.

Patrick Lehan of UMC has been named the American College of Cardiology governor for Mississippi.

Herbert Langford of UMC made presentations in Rothenburg, West Germany and Interlaken, Switzerland recently and also was speaker at the International Symposium on Potassium in Cardiovascular and Renal Medicine in Baltimore.

Richard Miller of UMC made a presentation at the Case Western Reserve University School of Medicine in Cleveland, Ohio, recently.

Doyle A. Morrison has associated with the Urology Clinic, 514-F East Woodrow Wilson in Jackson, for the practice of urology, urological surgery and urological oncology.

Charles M. Murry of Oxford has been named a Paul Harris Fellow by Rotary International.

Charles Parkman of Hattiesburg has been elected to serve a three-year term on the Mississippi Lung Association Board of Directors.

Calvin P. Poole, Jr. has associated with The Street Clinic in Vicksburg for the practice of obstetrics and gynecology.

Roland B. Robertson received special recognition at the recent Mississippi Lung Association annual meeting for his leadership as president of the MLA Board of Directors.

Robert A. Sanford of UMC made a presentation at the Pediatric Brain Tumor Workshop in Ontario, Canada, recently and also presented a paper at the

Neurosurgical Society of America meeting in Coronado, California.

ROBERT R. SMITH made a presentation at the Society of University Neurosurgeons meeting in Seattle, Washington.

DWALIA SOUTH of Ripley presented a symposium on depression for the Tippah County Mental Health Society and also presented seminars for the American Cancer Society at Tippah County Hospital.

EDWIN B. STRUVE announces the opening of his office for the general practice of medicine at Community Medical Center, Sandersville.

DAVID ALLAN TIMM has associated with Children's Clinic of Natchez (JOHN D. COFFEY and DONALD E. KILLELEA) for the practice of pediatrics.

Medico-Legal Brief

Nurses' Services Held Not To Be Unlawful Practice Of Medicine

Services performed by nurses did not constitute the unlawful practice of medicine, the Missouri Supreme Court ruled.

The agency employing the nurses provided medical services to the general public in the fields of family planning, obstetrics, and gynecology. Two nurses and five physicians employed by the agency petitioned the court to declare that the practices of the nurses were authorized under the state nursing law and to enjoin the Board of Registration for the Healing Arts from enforcing an unauthorized practice of medicine provision. The trial court denied the petition, and the nurses and physicians appealed.

The nurses had postgraduate training in obstetrics and gynecology. The services that the Board complained of included taking of history; breast and pelvic examinations; laboratory testing of Pap smears, gonorrhea cultures, and blood serology; providing and giving information about oral contraceptives, condoms, and intrauterine devices; dispensing certain designated medications; and providing counseling services and community education. All of the nurses' services were done pursuant to written standing orders and protocols signed by the physicians.

The Missouri Supreme Court pointed out that the Nursing Practice Act of 1975 redefined the term "professional nursing," eliminating among other things the requirement that a physician directly supervise nursing functions. Also, a nurse might be permitted to assume responsibilities previously not considered to fall within the field of professional nursing so long as they were consistent with the nurse's "specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences." The court found that the nurses' acts clearly fell within this legislative standard.

The court said that in providing treatment prescribed by a physician in standing orders or protocols a nurse undertakes only a nursing diagnosis, rather than a medical diagnosis, when she or he finds or fails to find symptoms described by a physician in standing orders and protocols. The court found that there was no evidence that the nurses' assessments and diagnoses exceeded the limits of their knowledge or the limits prescribed by the physicians' standing orders and protocols. Finding that the nurses' acts did not constitute the unlawful practice of medicine, the court reversed the lower court's judgment. — *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo.Sup.Ct., Nov. 22, 1983)

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BOARD CERTIFIED head and neck surgeon now finishing facial plastic surgery fellowship. Desire opportunity or association in which to develop facial plastic and reconstructive surgery practice. Contact Donn R. Chatham, M.D., 1516 South 20th St., Birmingham, AL 35205; (205) 933-8799 or 871-0429.

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FAMILY PHYSICIAN. Ideal practice opportunity in thriving central Mississippi community of 5,000. Surrounding trade area has 25,000 population base. Excellent opportunity for OB practice if desired. Situated within one hour's drive of Jackson. Reply to Box B, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

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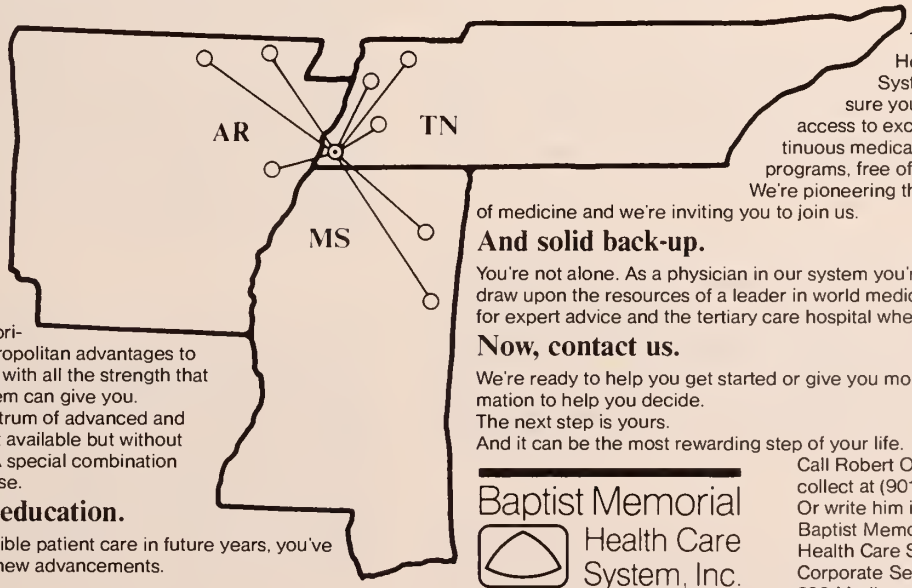

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September 1984

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90000 - 90080	-- office visit
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92002 - 92014	-- ophthalmological office visit
90835, 90841, 90843, 90844, 90880	-- psychiatric office visit

Co-payments cannot be collected from certain groups of recipients and even when certain services are provided. These exceptions are children under age 18, nursing home residents, pregnant women, family planning services, and recipients covered by both Medicare and Medicaid.

The December 1983 issue of the New York State Journal of Medicine has been acclaimed for its analysis of the world cigarette pandemic. An extra press run has enabled the journal to respond to the demand for additional copies. Copies are available ($5.00) from the journal's circulation department, P.O. Box 5404, Lake Success, NY 11042. Also available are copies of a more recent issue (July 1984) which is an authoritative review of current issues and controversies regarding offshore medical schools.

Physicians have until the end of this month to decide whether to become "participating" or "nonparticipating" physicians under the new Medicare regulations. The MSMA Report of August 24 included a review of the fee freeze and participating/nonparticipating requirements, and also outlined recommendations by the MSMA Board of Trustees.

"What Your Patients Should Know...About DRGs and the Prospective Payment System" is a booklet designed to assist physicians in answering patient inquiries. Copies are available for $1 each for up to 99 copies, 75¢ each for 100-500 copies, and 60¢ each in larger quantities. Write to the AMA Order Dept. OP-336, P.O. Box 10946, Chicago, IL 60601.

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Patsy Silver

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In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

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REFERENCE:

1. Cassisi N, Cohn A, Davidson T, et al: Diffuse otitis externa: Clinical and microbiologic findings in the course of a multicenter study on a new otic solution. *Ann Otol Rhinol Laryngol* 86(suppl 39, pt 3):1-16, 1977.

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Precautions: If sensitization or irritation occurs, medication should be discontinued promptly. Patients who prefer to warm the medication before using should be cautioned against heating the solution above body temperature, in order to avoid loss of potency.

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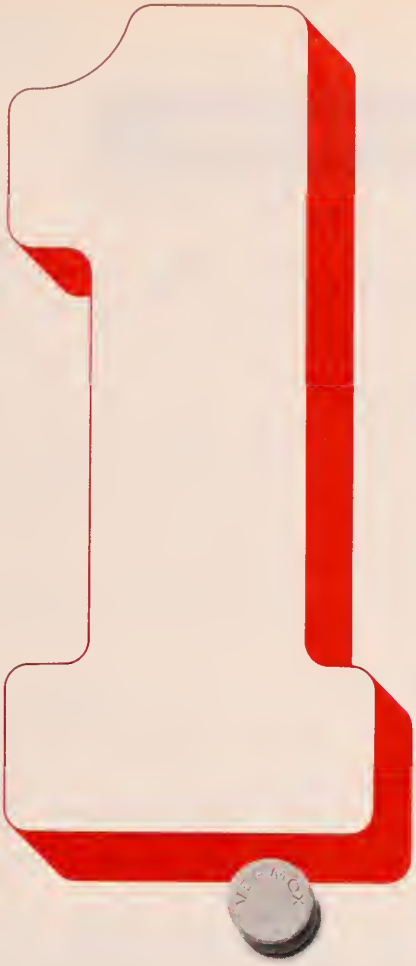

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State and Local

Mississippi State Medical Association, 117th Annual Session, May 15-19, 1985, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 26-29, 1985, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Pate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Secy., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Dan Jones, Secy., P.O. Box 2756, Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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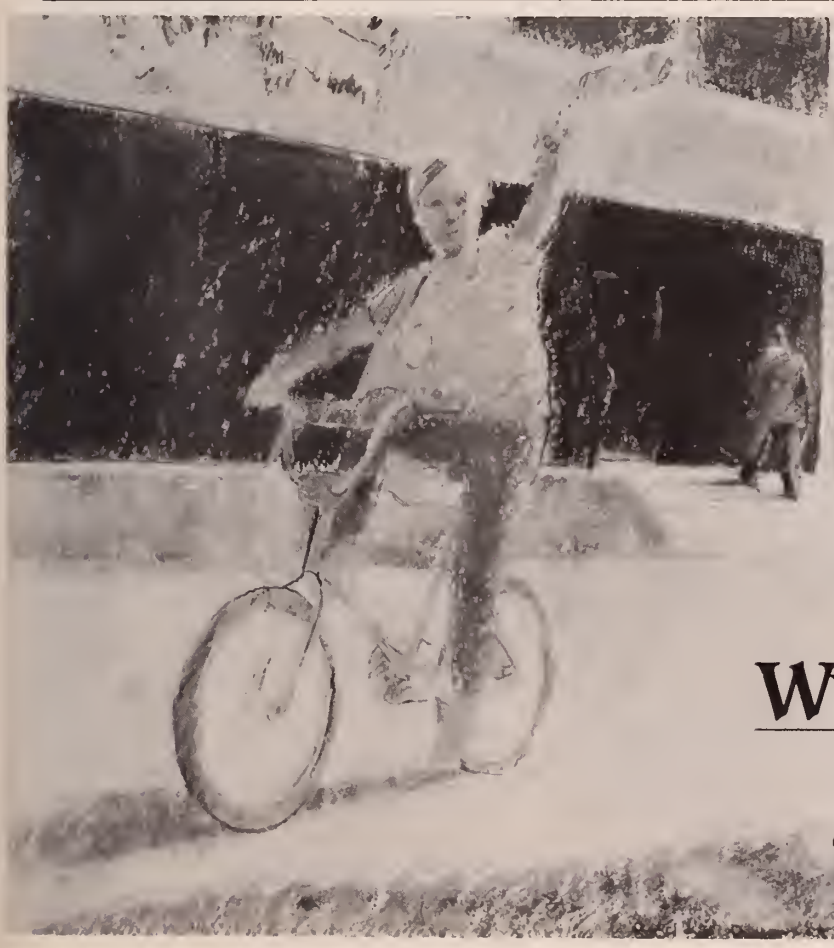

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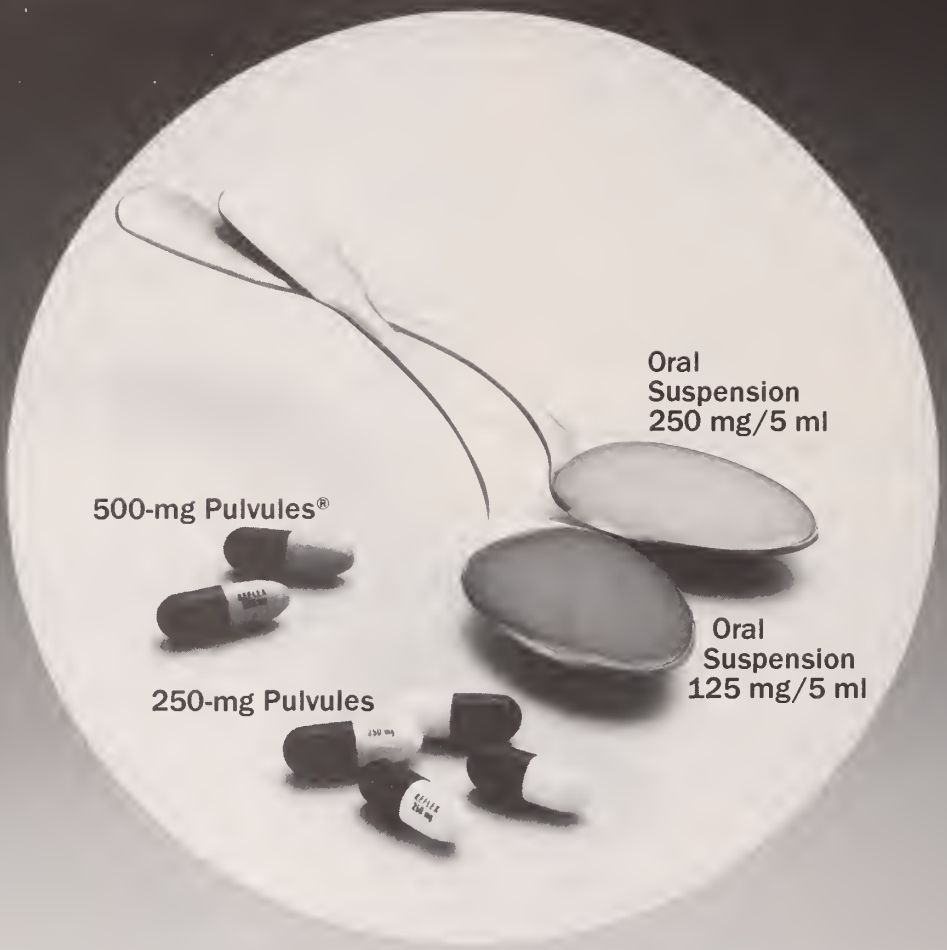

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DATELINE

Association Dues Survey Information

Chicago, IL - A recent AMA survey of state and county medical association dues reveals a mean of $264.18 annual state dues and $160.37 annual county dues. Annual state association dues range from a low of $135 in Missouri to $445 in Wisconsin. Annual county medical society dues range from $0 to $600. MSMA will charge annual dues of $235 in 1985, and county society dues will range from $0 to $50.

Project MEDVOTE - Making Medical Votes Count

Jackson, MS - MSMA and other state associations have joined the AMA in conducting MEDVOTE 84, a drive to register physicians, their spouses and employees to vote. Nationwide, medical families and employees represent an estimated 1 million eligible voters, but one study showed 40% of physicians are not registered. Mrs. Terrell D. (Barbara) Blanton, MSMA Auxiliary president, is serving as MEDVOTE chairman for the state.

Hospitals Can Benefit From Swing-Bed Program

Jackson, MS - More Mississippi small rural hospitals may now implement swing-bed programs following the lifting of the CON moratorium. Previously, only four hospitals had been able to utilize the swing-bed concept. For more information about the swing-bed program and how it can benefit your patients and hospital, contact Mary Winslow, Mississippi Hospital Association, P.O. Box 16444, Jackson, MS 39236-0444.

Is DRG System Working At Your Hospital?

Chicago, IL - How is the DRG system working at your hospital? AMA's DRG Monitoring Project is collecting observations about the program and will use the information in pursuing modifications to the prospective pricing system and in developing programs to assist physicians in dealing with it. Send written comments to DRG Monitoring Project, AMA Department of Health Care Resources, P. O. Box 10947, Chicago, IL 60610.

Statistics on Physician Population

Chicago, IL - The physician population of the U.S. as of December 1982 was 501,958, according to the latest figures from the AMA Physician Masterfile. Of these, 408,663 (81.5%) were engaged in direct patient care activities. Women and foreign medical graduates made up 12.8% and 21.4% of the total, respectively. FMGs increased 87.5% from 57,217 in 1970 to 107,284 in 1982.

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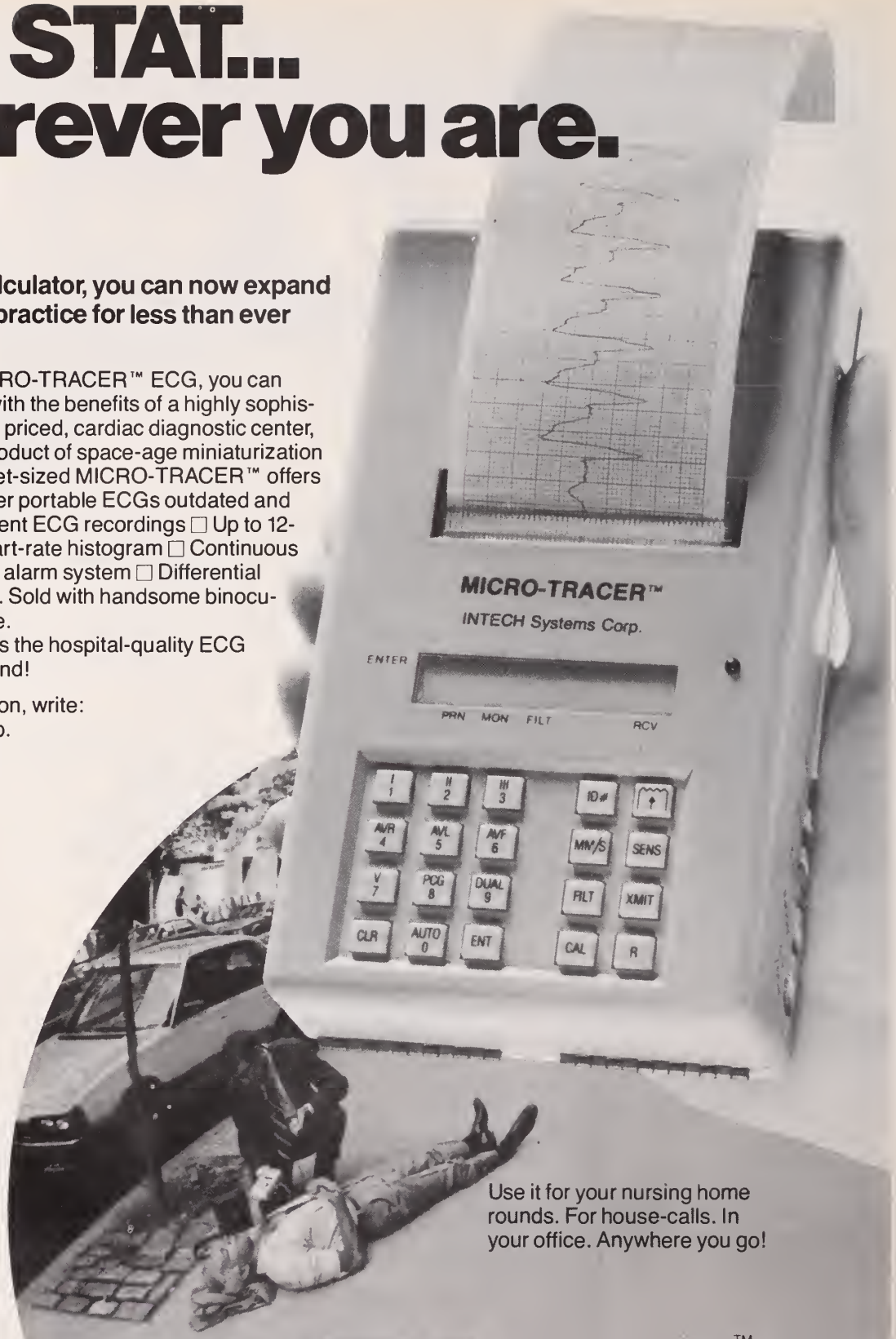

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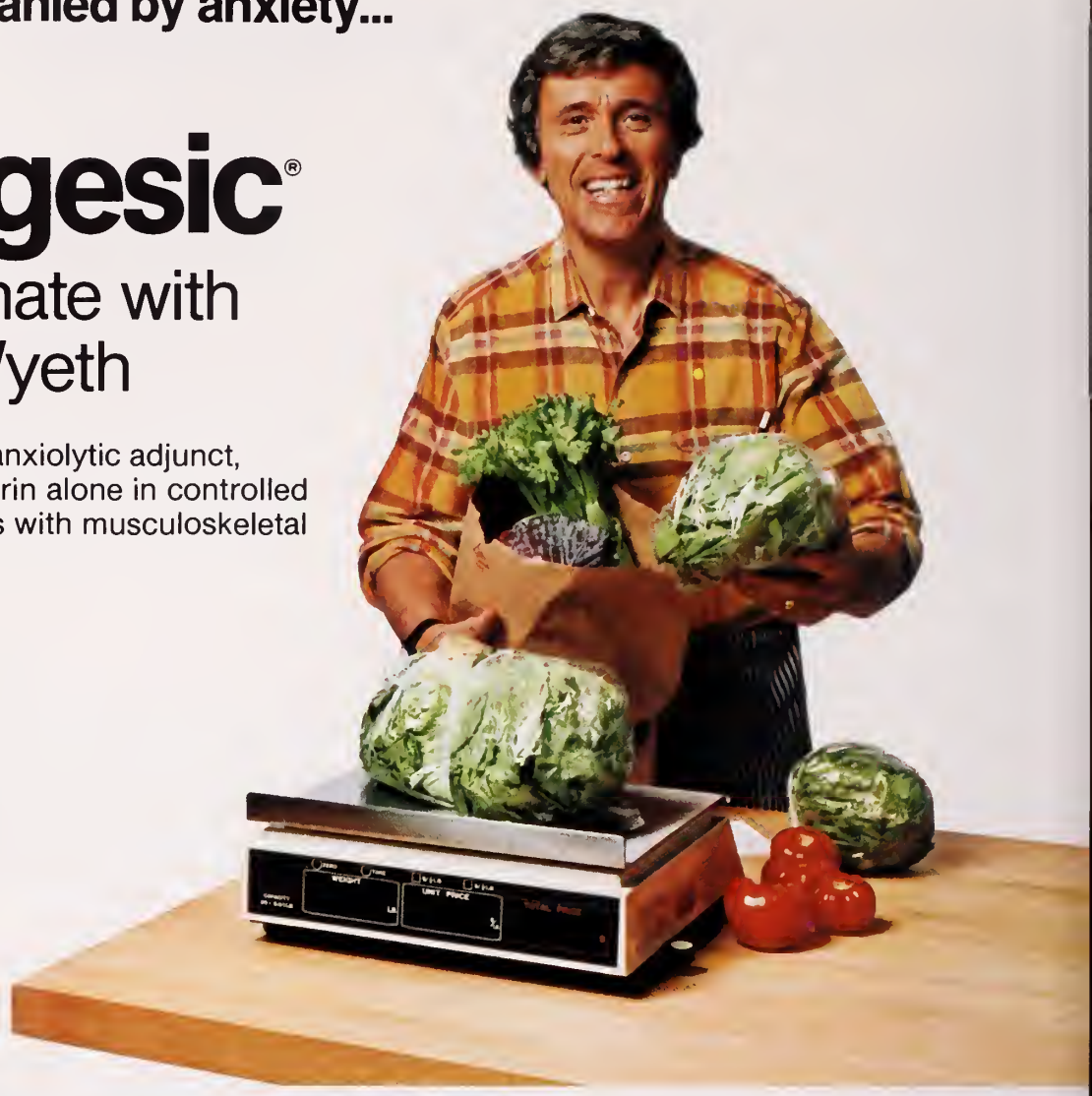

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Each tablet contains 200 mg meprobamate and 325 mg aspirin

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CONTRAINDICATIONS:
ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds.

MEPROBAMATE: Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS:
ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION:
An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under.

PRECAUTIONS:
ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate-mebutamate and meprobamate-carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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JOURNAL OF THE MISSISSIPPI MEDICAL ASSOCIATION
September 1984, Volume XXV, Number 9

ORIGINAL PAPERS

Neglected Iron Deficiency

BERNARD J. DREILING, M.D.
MARTIN H. STEINBERG, M.D.
Jackson, Mississippi

Iron deficiency remains one of the major causes of anemia, and its presence, particularly in adult men, should initiate a search for blood loss, according to the authors. They report a review of 156 patients and conclude that failure to adequately evaluate patients with iron deficiency and to search for a site of blood loss is common. They note that this seriously compromises the management of the patient.

IRON DEFICIENCY ANEMIA remains one of the major causes of anemia encountered in medical practice. Its presence in adults should initiate a search for blood loss, since the leak of iron contained in shed erythrocytes is responsible for the development of this anemia in the overwhelming majority of cases.[1] The necessity to look for blood loss is apparently not adequately recognized by physicians and particularly by house staff. Yet patients with iron deficiency are often treated with iron or even blood transfusion without further work-up. Such an approach results in frequent recurrence of the disease and at times the neglect of serious bleeding lesions. To determine the extent of this inadequate management in general hospital practice, we analyzed the records of 156 patients with iron deficiency anemia seen in our hospital and detected by the absence of marrow iron stores. In this retrospective analysis we found iron deficiency to be poorly evaluated and the management of some individuals to be seriously compromised because of this.

Methods

The presence of iron deficiency was unequivocally established by the total absence of iron in marrow aspirates stained with the Prussian Blue reaction.[2] Standard hematologic techniques were used, and the hemoglobin concentration, hematocrit reading and erythrocyte indices were measured using an electronic cell counter. Serum iron and total iron binding capacity were measured by the method of Goodwin et al.[3] At the time these patients were studied, serum ferritin and free erythrocyte protoporphyrin measurement were not generally available. All bone marrow examinations in our hospital are done by the Hematology Service. The records of all patients having absent stainable bone marow iron were reviewed, as were the records of all anemic patients seen by us in consultation during this same year period.

Statistical analysis was done using the BMD 02S-Contingency Table Analysis (04) and an IBM 370/155 computer, with a P value equal to or less than 0.05 considered significant.

Results

We found 156 patients with absent iron stores all of whom were anemic except for a small group with polycythemia. There were 137 anemic patients who had stainable bone marrow iron seen in this same

From the Hematology-Oncology Section, VA Medical Center and the Division of Hematology, Department of Medicine, University Medical Center, Jackson, MS.

period (see Table I). Thus iron deficiency anemia was present in over half the anemic patients we evaluated in consultation. The hematologic data in iron deficient patients is found in Table II. A reticulocyte count and determination of serum iron and total iron binding capacity were done in only 62% and 75% of these patients. Sixty-three percent of iron deficient patients were caucasian, 36% black, and 1% of other races. In contrast 63% of non-iron deficient patients were black (x^2-24.3; $P < 0.0005$). There was no significant difference in the age of iron deficient patients and those patients with anemias of other causes.

Of eight patients (5%) found to have splenomegaly, one had polycythemia vera, one Felty's syndrome, one portal hypertension, one splenic rupture and one had two previous abdominal surgical procedures. A cause for splenomegaly other than iron deficiency was not found in the remaining three patients.

A gastrectomy had been done one to 22 years (mean ± S.D. 10.85 ± 6.3) before diagnosis in 29 (18%) patients with iron deficiency. Only six patients (4%) with anemia of other causes had gastrectomy (x^2 14.1; $P < .0005$).

The stool contained occult blood in 53 patients and was negative in 75 cases. In 28 individuals there was no record of this test being done.

A source of blood loss was discovered in 70 patients (45%) and in 66 (94%) this was located in the gastrointestinal tract. The results of studies of the gastrointestinal tract are presented in Table III. Fifty-three (34%) patients did not have an upper GI series, 65 (42%) had no barium enema, and proctoscopy was not done in 103 (66%) instances. Of the 103 individuals who had upper GI series done, 52 had the source of blood loss discovered. Fourteen of the 51 patients who failed to have upper GI X-rays had the source of blood loss found (x^2 7.4; $P < 0.01$). Of 91 patients having barium enemas, 45 had a source of blood loss found compared with 21 of 63 patients not having this examination (x^2 3.9; $P < .05$). Of 53 patients undergoing proctoscopy, a source of blood loss was found in 30 instances while only 36 of 101 individuals not proctoscoped had a site of blood loss discovered (x^2 6.2; $P < .02$).

The response to treatment with iron replacement was documented by an increase in reticulocyte count in 13 instances, a rise in hemoglobin concentration in 28 patients and both in 62 cases. No response was noted in six patients. Evaluation was not possible in 47 individuals due to incomplete data.

Sixteen patients were seen on two occasions for iron deficiency and two individuals presented with iron deficiency three times during the period of observation. In six of these cases, a source of blood loss was found after reinvestigation.

TABLE I
NON-IRON DEFICIENT ANEMIAS

Diagnosis	*Number*
Megaloblastic anemia	10
Anemia of chronic inflammation	61
Hemolytic anemia	11
Miscellaneous causes	37
Unknown	18

TABLE II
HEMATOLOGIC FINDINGS IN IRON DEFICIENCY

	Patients	*Mean ± S.D.*	*Maximum*	*Minimum*
Age (yrs.)	156	57.5 ± 13.6	88	22
Hemoglobin (g/100ml)	156	9.5 ± 2.9	19*	2
Reticulocytes (%)	97	2.1 ± 2.2	19	1
MCV (fl)	120	80.8 ± 13.0	134	58
Fe (μg/100 ml)	117	52.7 ± 22.1	129	16
TIBC (μg/100 ml)	117	342.1 ± 85.9	575	130

* Patients with polycythemia.

TABLE III
THE EVALUATION OF POSSIBLE SOURCES OF BLOOD LOSS IN IRON DEFICIENCY ANEMIA

Examination	*Number Done*	*Findings*	*Number of Patients*
Upper GI Series	103	Normal	17
		Active benign ulcer	13
		Old ulcer	13
		Hiatal hernia	29
		Carcinoma	3
		Gastritis	4
		Gastrectomy (alone)	14
		Other	10
Barium Enema	91	Normal	65
		Diverticuli	16
		Carcinoma	5
		Other	5
Proctoscopy	53	Normal	34
		Hemorrhoids	10
		Carcinoma	2
		Other	7

Discussion

Iron deficiency anemia remains one of the most prevalent hematologic disorders found in hospitalized patients and accounted for over half of the anemic patients referred during the period of this report. It was almost three times as common as the next most frequent anemia, that of chronic inflammatory disorders.

All of our patients were hospitalized men over 20 years of age, veterans, and residents of a southern, largely rural state. Thus, they do not reflect the composition of general population of this country nor the population of our region at risk for developing iron deficiency. It is not possible to estimate the frequency of iron deficiency in our hospitalized population, since all anemic patients are not seen by us. Additionally, as the sole criterion for entry into this study was the absence of bone marrow iron, the rare patient with polycythemia vera who had absent iron stores was included in our data. Patients who might have stainable bone marrow iron but decreased total body iron were excluded from analysis. With these limits recognized, the following points may be made.

The yield of positive findings during studies of the gastrointestinal tract was high (see Table III). Ten patients were found to have carcinoma, though in many instances the presence of an abnormality was not felt to be associated with the source of blood loss. Almost one third of patients did not have any contrast or endoscopic studies of their gastrointestinal tract. Gastrointestinal blood loss is the major cause of iron deficiency in men.[1] Upper gastrointestinal series was not done in 34% of iron deficient patients, 42% did not have barium enema, and in 66% a proctoscopy was not done. As iron deficiency is a symptom of underlying disease, a search for the source of iron loss is of paramount importance. A significantly higher number of patients having conventional gastrointestinal radiography and proctoscopy had an identifiable source of blood loss indicating the value of these procedures for therapeutic decisions.

Splenomegaly occurred in 5% of patients with iron deficiency, but in only 2% was iron deficiency anemia believed to be its cause. Two of these individuals had profound anemia with Hb levels of 4 and 5 g/dl ml. Significantly fewer black patients had iron deficiency than had anemia of other causes. Our data do not provide a ready explanation for this curious finding.

A striking relationship between history of gastrectomy and the presence of iron deficiency existed. Patients post-gastrectomy are especially likely to become iron deficient due to depleted iron stores preoperatively, inadequate replacement of blood lost during surgery, impaired absorption of dietary iron, continued oozing from marginal ulcers, intestinal hurry, duodenal bypass, and atrophic gastritis of the remaining gastric remnant.[5-7]

Iron deficiency in infants and children may occur for reasons unrelated to blood loss, and its presence in premenopausal women is most commonly related to the loss of blood from menstruation and parturition. The prevalence of iron deficiency in these groups has been the subject of reviews.[8-10]

The diagnosis of iron deficiency is usually not difficult. We have reviewed the management of iron deficiency in a group of adult men. The neglect of diagnosed iron deficiency in many instances seems clear and may compromise the management of the patient. ★★★

Dr. Dreiling: VA Medical Center, Jackson (39216)

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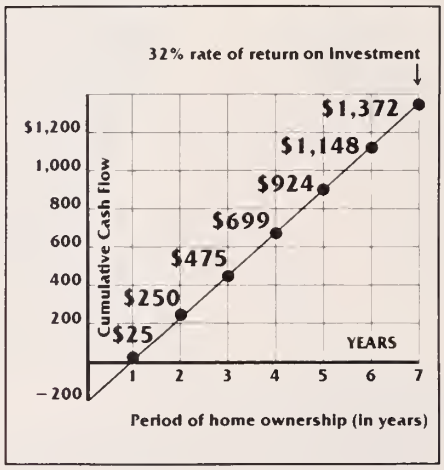

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Metastatic Tumors of the Small Intestine: Case Report and Review of Literature

ANUPAM ROUTH, M.D.
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Metastatic tumors of the small intestine are very rare. The most common sites from which metastasis arises are carcinoma of the cervix and malignant melanoma. The authors report a case in which the primary site is in the soft palate. They suggest this is probably the first reported case of metastasis to the small intestine arising from the soft palate.

PRIMARY CARCINOMA of the small intestine is uncommon.[1] The small intestine is generally involved in the terminal stages of abdominal carcinomatosis,[2] but metastatic tumor of the small intestine is extremely rare. The most common sites of the primary for metastatic tumor of the small intestine are carcinoma of the cervix and malignant melanoma. In a series reported from Mayo Clinic[3] the primary site in one case was from the skin of the chin.

In the case report below, the primary site was in the soft palate. This is probably the first reported case of metastases to the small intestine from this primary site, ie the soft palate.

Case Report

Mr. C. J. is a 60-year-old white male who complained of anorexia, vomiting, and postprandial pain and weight loss of 25 lbs. After he was admitted into the hospital for investigation, he told his doctor about a lump at the back of his throat.

The patient was examined by the ENT surgeon for this throat problem. The surgeon performed a direct laryngoscopy, esophagoscopy, and nasopharyngeal examination with biopsy. Examination of the palate showed an ulcerative lesion in the soft palate on the right side. The tumor invaded the anterior tonsillar pillar and extended along the tonsil. The tumor extended almost to the midline in the soft palate and proximally to the junction between the hard and soft palates. The true cord, false cord, aryepiglottic folds, and subglottic area were normal and the esophagus was normal. There were no palpable neck nodes. The tumor was staged as $T_3N_0M_0$. Histology was reported as poorly differentiated squamous cell carcinoma.

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An upper GI series was normal, as was barium enema, which was done twice. CT scan of the abdomen showed a questionable mass in the region of the head of the pancreas. Ultrasound revealed a normal pancreas but presence of many stones in the gallbladder.

An abdominal aortogram showed marked atherosclerotic disease. Endoscopy of the upper GI tract showed a 1.5 x 1.5 cm. prepyloric ulcer. The patient's entire antrum along the greater curvature was scarred with several active ulcers, the largest of which was 2.5 x 3.0 cm in size. Biopsies showed normal mucosa. No evidence of malignancy was seen.

The patient's gastric symptoms did not improve with conservative management. It was thought that his main problem was due to gastric ulcer. The patient was advised to have a gastric resection with possible vagotomy and antrectomy. In December 1982 he underwent surgery, at which time a hard mass was noted in the mid-jejunum which was causing mild obstruction. The lesion was resected completely. Frozen section was reported as adenocarcinoma, and a careful search for the primary was made during the surgery. The remainder of the small bowel and large bowel were examined properly. The kidneys and pancreas were carefully inspected. In the stomach, an ulcer about 4 cm in diameter was

found in the antrum. There was no other tumor seen or felt in the abdomen. The patient underwent vagotomy, antrectomy, Billroth I anastomosis, and also cholecystectomy.

The permanent histology of the mass in the small intestine was reported as metastatic poorly differentiated squamous cell carcinoma with vascular and lymphatic invasion. The case was presented to the Tumor Board for discussion and further management. The consensus was that it was a metastatic tumor arising from the soft palate.

The treatment plan was to administer radiation therapy to the primary tumor in the soft palate as well as the cervical area, including a low neck port to treat the supra and infraclavicular regions. Since the lesion in the small intestine was resected completely, it was decided not to do anything to that area.

The patient received 900 rads in five treatments. He then suddenly developed severe pain in the abdomen. He was known to have vascular insufficiency of the superior mesenteric artery by previous aortogram. A diagnosis of mesenteric ischemia was made and the patient underwent exploratory surgery.

The jejunum was found to be necrotic for a distance of 25 cm. The healed anastomotic site from the previous antero-anterostomy was widely patent but was obviously gangrenous. There were obvious tumor nodules at the site of perforation. No palpable pulsation was felt in the superior mesenteric artery. A 90 cm segment of small bowel was excised. The surgeon did jejunal resection, iliojejunostomy with partial small ileal resection and ileostomy. The permanent histology showed mesenteric squamous cell carcinoma in the small bowel with involvement of the mesenteric nodes. The patient did not do well this time after surgery and expired 18 days after surgery. No autopsy was done.

Discussion

Metastatic tumors of the small intestine are extremely rare. There were only 26 cases reported at Mayo Clinic in the 50 year period from 1905-1955.[3] Histology of these primary tumors was malignant melanoma in 4 cases, squamous cell carcinoma in 11 cases, and adenocarcinoma in 11 cases. The most common primary sites were the cervix (8 cases) followed by malignant melanoma (4 cases), retrosigmoid area (4 cases), ovary (4 cases), and kidneys (3 cases). In one case the primary site was the skin of the chin. In the last case, route of spread was thought to be hematogenous.

Metastatic tumors in the duodenum from malignant melanoma were reported by Richman & Lipsay[4] and Beirne.[5] Shackelford[6] reported a case of mesenteric tumor in the duodenum from a myosarcoma of the uterus. Barclay & Kent[7] reported one case of metastatic tumor in the duodenum. The primary site was the kidney. Farmer[8] reported 14 cases of metastatic tumor in the small intestine in the period from 1950-1963. Six cases had multiple metastases in the body. In one case metastasis in the small intestine was the only site of metastasis. The primary site was the cervix in 5 cases, malignant melanoma in 4 cases, colon in 3 cases, and 1 case each from the lung and ovary. The route of metastases from the primary site to the small intestines is not clearly known.

Hayes & Burr[9] suggest that the metastasis to the small intestine generally occurred through the vertebral venous plexus of Batson.

Powell[10] suggested that metastasis to the small intestine can occur by any of the following routes: (a) permeation of lymphatic spaces in the connective tissue, (b) lymphatic embolization, (c) blood stream, and (d) peritoneal seeding, including direct implantation occurring at the time of surgery. In the case we report, the tumor must have metastasized by any of the routes suggested by Powell, most probably by lymphatic embolization. ★★★

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Diseases of Small Arteries and Veins

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SINCE WILLIAM HARVEY published his classic work on the circulation of blood in 1628, our knowledge of the circulatory system and the various pathologic states that alter it has increased tremendously.[1] Diagnosis of atherosclerotic occlusive disease involving the large and medium size arteries has been made increasingly precise with newer diagnostic techniques, both noninvasive and invasive. Modification of known risk factors, inasmuch as the general population is willing to modify its lifestyle, will slow the progression of atherosclerotic disease and in some instances prevent the devastating effects of this disease. Surgical endarterectomy or bypass techniques developed over the last 30 years, though not curative of the primary process, can be lifesaving and limbsaving.

In the area of diseases affecting the smaller arteries and veins, however, our knowledge of etiology and pathology is less precise and subsequently our treatments for the various diseases encountered are less efficacious. Add this to the fact that many of the diseases that involve small vessels are systemic in nature with multiple organ involvement and it is easy to see that some of these diseases can be very frustrating to diagnose and treat, and some are quite lethal.[2]

The aorta is classified as an elastic artery. It has an endothelium, a thick internal elastic membrane, a small or absent subendothelial space, and a thick media consisting of alternating layers of smooth muscle and elastic lamellae that consist of continuous sheets adjacent to large numbers of collagen fibers. Smaller branches of the aorta or its major branches are the muscular arteries, exemplified by the coronary arteries. They consist of endothelium, a continuous layer of basement membrane, an internal elastic lamella which is fenestrated lying in the subendothelial space, a variable number of layers of smooth muscle cells in the media, and adventitia made of collagen, fibroblasts, and other mesenchymal cells. The small arteries have no specific size definition. They are generally described as those vessels that do not have proper names that are branches of the medium size or muscular arteries. Also included are the vessels that are distal to the ankles and wrists: the palmar, plantar, and digital vessels. Histologically, the small artery has a flatter, less complex endothelium, the elastic tissue is less prominent, and the number of smooth muscle cells in the media decrease with the size of the vessel. Eventually, at a diameter of 30-40 microns the structure is considered an arteriole and possesses only a single layer of smooth muscle and lacks an internal elastic lamella. The capillary has endothelium, pericapillary cells, a few adventitial cells, and a basement membrane. They usually have an outside diameter of 15 microns or less.

Table 1 is a basic outline of the diseases affecting smaller arteries and veins, breaking them down according to anatomic (organic) and vasospastic (functional) groups. Within the organic category further breakdown can be done between occlusive and nonocclusive diseases, and it is evident that the majority of the diseases are in the occlusive category. These are further divided into degenerative, inflammatory, and thromboembolic groups. This outline tends to lend some sense of order to what is a very vast and disorderly array of diseases.

In the organic arterial occlusive disease category the first thing to consider are those diseases that are basically degenerative in nature: arteriosclerosis and Monckeberg's sclerosis. For lack of a better category diabetic microangiopathy has been included here.

Arteriosclerosis is primarily an intimal disease affecting the large and medium size muscular arteries. As such, the small arteries tend to be spared. Risk factor modification and direct surgical attack for this disease in its medium size vessel presentations is well known and need not be discussed here. Monckeberg's sclerosis, or medial calcification, was described in 1903 and was felt by its discoverer to be a separate pathologic entity from atherosclerosis, with no intimal involvement, and possibly little actual obliterative tendency. Most all physicians have seen calcified vessels on plain films of the

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TABLE 1
OUTLINE OF SMALL VESSEL DISEASES

I. Organic (anatomic)
  A. Occlusive
    1. Degenerative
    2. Inflammatory
      a. Infectious
      b. Vasculitides
    3. Thromboembolic
  B. Nonocclusive
II. Functional (vasospastic)

TABLE 2
CONNECTIVE TISSUE DISEASES

Periarteritis Nodosa
Systemic Lupus Erythematosus
Scleroderma
Dermatomyositis
Rheumatoid Arthritis
Giant Cell Arteritis
Systemic "Allergic" Angiitis
Acute Rheumatic Fever
Wegener's Granulomatosis

extremities and this process may involve the palmar and plantar arches and digital vessels as well.

Small vessel degenerative changes in diabetes mellitus have been described as including thickening of the basement membrane, fibrillary changes in elastic tissue, and endothelial proliferation. Though controversy has raged concerning the relationship of these changes to "garden variety" atherosclerosis, some points can be emphasized:

1. Diabetics have a 50-70 times increased incidence of vascular insufficiency compared to the nondiabetic population, and they have a higher amputation rate than a similar nondiabetic population with peripheral vascular disease.[3]
2. Arteriosclerosis occurs at an earlier age in diabetics.
3. Arteriosclerotic changes occur more distally in the diabetic.
4. There is a distinct angiopathy present that seems to be unrelated to the biochemical abnormality. This is primarily manifested in the retinal and renal vasculature, but occurs to some degree in other tissues as well (see Figure 1).

The inflammatory angiopathies include a legion of disorders that often have various systemic manifestations even apart from the small vessel inflammation. They can be considered to be either infectious or "autoimmune" in nature.

A commonly known but now less commonly seen infectious vascular disease is syphilis. It primarily involves the larger elastic vessels such as the aorta, but may well on occasion involve smaller muscular arteries, especially in the central nervous system where it may induce endarterial intimal proliferation converting an artery into a solid cord.

Smaller arteries passing through an infected area such as pneumonic suppuration or bacterial cellulitis may also become involved in an acute arteritis and may thrombose, develop mycotic aneurysm, or heal with scarring and intimal proliferation. Tuberculosis may also produce a nodular vasculitis.

The "collagen vascular diseases" or angiitides are a group of much studied but still poorly understood disorders. They all usually include a rather nonspecific inflammatory cellular infiltrate of the vessel wall which may lead to intimal edema, proliferation, and occlusion, with subsequent multi-organ failure. An immune complex mechanism of damage is thought to occur in many of these diseases.[2, 4, 5] Table 2 contains a representative list of these diseases. Though space does not allow even a brief discussion of each of these diseases, the type of pathology encountered is illustrated by considering three of them.

In 1866 Kussmaul and Maier described the gross and microscopic findings of periarteritis nodosa. They found focal nodular areas of inflammation scattered along medium and small arteries, concentrated especially at the branches.[6] Microscopically the lesions demonstrated partial or circumferential involvement, with edema and fibrinous exudate early on. Later, fibrinoid necrosis of the media occurred, with destruction of the internal elastic membrane and a granulocytic infiltrate involving the full thickness of the artery. This became chronic with lymphocytes and plasma cells. The intima in the area of the lesion proliferated and the narrowed lumen proceeded to thrombose. Multiple organ involvement is the rule in periarteritis nodosa, with renal, cardiac, intestinal, nervous, pulmonary, and cutaneous lesions. Treatment is with steroids. In one series the five-year survival rate with steroids was 48%, without steroids it was 13%. More recent series have produced even better results with the addition of immunosuppressive drugs such as cyclophosphamide, and plasmapheresis is being tried as a therapeutic modality.[5] Surgery is required only for diagnostic biopsy or for amputation or debridement of necrotic tissue if necessary.

Systemic lupus erythematosus, because of its pro-

tean manifestations, has been called "the great imitator." Its obstructive organic lesions are of a nonspecific inflammatory and proliferative type, and are felt to be related to an immune complex mechanism involving DNA, anti-DNA antibody, and complement. Renal failure, CNS disorders, cutaneous ulceration, and digital gangrene can occur from the vascular involvement. Figure 2 is a photomicrograph depicting the pathologic changes in a vessel in a patient with systemic lupus erythematosus. Once again, steroids play a role in treatment, with surgery only playing a minor role in managing gangrenous complications.

Scleroderma patients have a propensity to develop digital ischemia and gangrene because approximately 90% of patients may have occlusive disease of the digital arteries. Histologically the vessels are found to have medial hypertrophy and intimal proliferation, along with perivascular fibrosis. Sympathectomy is usually of little benefit, but proximal surgically correctible lesions must be ruled out.

Though it does involve inflammation of the vessel wall, thromboangiitis obliterans is really quite different from these other angiitides in that it is usually always limited to the small and medium size vessels of the extremities distal to the knees and elbows. As the title of Buerger's 1908 article states, it can lead to spontaneous gangrene.[7] The etiology of this disease is uncertain but there has been noted to be a very close relationship between thromboangiitis obliterans and smoking. Pathologically one sees focal lesions in the smaller arteries of the extremities with recanalizing thrombus in the lumen, well-preserved media with lymphocytic and fibroblastic invasion . . . in other words a focal, inflammatory, nonnecrotizing panangiitis with thrombosis. Adjoining veins may be involved also. The lesions may heal and recanalize with an adjoining fibrous reaction involving the vein and the nerve. Typical atherosclerotic lesions are absent. This is usually a disease of younger men and has a reported incidence of twelve per 100,000 population, though it seems to have become more rare in the past 25 years. Foot claudication, ischemic rest pain, cyanosis, and digital gangrene are the hallmarks of the clinical presentation. Raynaud's phenomenon and superficial thrombophlebitis may occur. Angiography demonstrates attenuated lumina of tibial, radial, and ulnar arteries. The affected segments tend to be long and many helical collateral channels open up around involved arteries. Proximal vessels are usually normal. The lower extremity is almost universally involved, but half of the patients will also have upper extremity involvement.

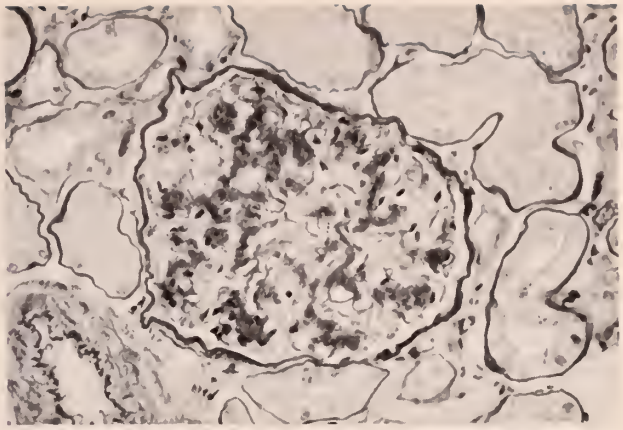

Figure 1. Photomicrograph of renal biopsy specimen from a patient with end stage renal disease secondary to diabetic glomerulosclerosis, classically described as Kimmelstiel-Wilson disease. Heavily stained hyaline deposits in the glomerular vessels are readily apparent with this PAS stain.

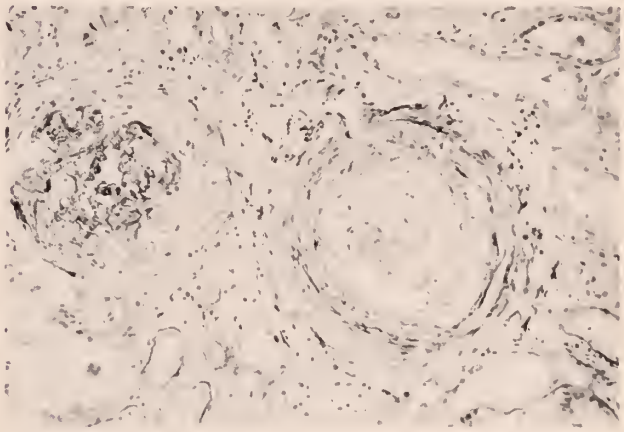

Figure 2. Photomicrograph of a renal biopsy specimen from a patient with renal impairment secondary to systemic lupus erythematosus. Note the nearly destroyed glomerulus on the left with crescent formation, and the small artery on the right with a few inflammatory cells and organizing intraluminal thrombus.

Treatment is simple . . . abstain from smoking. Unfortunately this is rarely done. Sympathectomy produces a variable result, but does nothing for the main problem. Amputation may be necessary. Anticoagulants, steroids, and vasodilators have been tried but with little proven efficacy.

Occasionally, small fragments of clot or atheroma may dislodge from an aneurysm, atheroma, or cardiac thrombus upstream and embolize into the smaller distal vessels (see Figure 3). Because of the protective effects of collateral circulation this phenomenon probably occurs more commonly than is

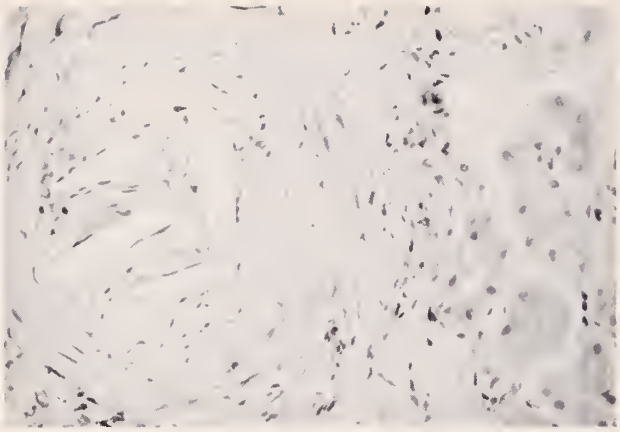

Figure 3. Photomicrograph of intrarenal artery from renal biopsy specimen demonstrating "cholesterol clefts," empty spaces produced by the removal of cholesterol from the specimen that contains an atheroembolus. This finding is highly suggestive of embolic occlusion from ulceration and embolization from a proximal occlusive atherosclerotic lesion.

clinically appreciated. Occlusion of the small vessels of the digits may be extensive enough that painful ischemia and gangrenous changes may well occur. In the cerebral circulation the clinical manifestation is the transient ischemic attack. These patients may present with palpable distal pulses but with an obviously gangrenous digit. A search must be made for sources of emboli upstream, such as intracardiac thrombus or aneurysms or ulcerated atheromata involving the proximal circulation. Antiplatelet drugs or anticoagulants may be used, but on occasion repair or bypass of the proximal lesion may be indicated to prevent slow persistent destruction of the distal circulation by recurrent embolization episodes.

Aneurysms and arteriovenous malformations comprise the group of nonocclusive organic lesions. Though primarily thought of as a disease of large or medium size vessels, aneurysms do occur in smaller vessels, the most common example being the microaneurysms described in the retinal arteries of the diabetic. Of more clinical significance is the AVM, which may be congenital or acquired. Their primary detrimental clinical manifestation may be hemorrhage, as in intracerebral or colonic arteriovenous malformations. Definitive treatment is tailored to the specific case, but usually involves surgical excision or ablation.

The functional group of small vessel diseases are classified thusly because of a lack of histologic demonstration of a specific anomaly of the vessel. Signs and symptoms of these diseases are still related to a relative decrease in blood flow through the involved vessels, but it is usually due to spasm of the vessels or to an abnormality of viscosity of the blood itself flowing through the vessels.

In 1862 a Parisian physician, Maurice Raynaud, published his classic "De l'asphyxie locale et de la gangrene symetrique des extremities," which described what is now felt to be a heterogeneous group of patients that had two major clinical presentations. The first group had episodic occurrences of painful, cold fingers and hands which initially had an ashen or cyanotic hue, then later changed to a fiery red color, which slowly resolved. These episodes tended to occur upon exposure to cold or sudden emotional stimuli and were felt to be secondary to vasospasm. The other group of patients Raynaud described had symmetrical occurrence of gangrene which involved either the tip of a digit or even an entire digit and portions of the extremity. In many of these cases there was no obvious history of preceding episodic color changes suggestive of vasospasm. Several critical reviewers have felt that many of the cases Raynaud described were indeed due to organic vascular disease, especially those with extensive gangrene. It has also become apparent that the vasospastic episodes with the previously described color changes are not due to one defined disease that can be called "Raynaud's disease," but are a clinical manifestation or phenomenon that can be associated with a myriad of other diseases, as depicted in Table 3. If, after extensive observation and study, no obvious associated disease can be found, a patient with Raynaud's phenomenon may be considered to have Raynaud's disease. It occurs about five times as frequently in women, and usually in the first and second decades of life. Eighty percent of cases occur before age 40. Fourteen percent of cases suffer from migraine headaches, and 9% are hypertensive. Cold exposure is the most common precipitating factor, about one-fourth of cases are precipitated by cold or emotion, and very few are triggered by emotion alone. Vasospasm is thought to be the major physiologic cause of the episodes, but some investigators feel there is more to the disease than this. Whether the fault lies in too much sympathetic stimulation or in excessive sensitivity to stimulation no one can say. Others have felt that the microcirculatory insufficiency is due to excessive blood viscosity related to supranormal levels of fibrinogen. In advanced cases of Raynaud's disease some degree of intimal thickening has been noted histologically, but this is always present to some degree in persons over 50 years of age anyway. Angiography will show narrowing of the digital arteries in Raynaud's disease

TABLE 3
CONDITIONS THAT MAY BE ASSOCIATED WITH RAYNAUD'S PHENOMENON

Raynaud's Disease
Buerger's Disease
Thoracic Outlet Syndrome
Arteriosclerosis Obliterans
Embolic Arterial Occlusion
Occupational Trauma
(Pneumatic Hammer Disease)
Ergotism
Pheocyromocytoma
"Collagen Vascular" Diseases
Cryoglobulinemia

but not distinct organic occlusion unless one is dealing with Raynaud's phenomenon related to some other disease process. As in many diseases that are often self-limited and improve on their own with time, the best approach with Raynaud's disease is conservative. Usually assurance and avoidance of cold exposure suffice, as well as consideration of moving to a warmer climate. Approximately 80% of cases will improve with time and conservative preventive and symptomatic treatment. More severe forms may be improved with oral or intraarterial vasodilators, the most commonly used being reserpine, though guanethidine, aldomet, prazosin, and phenoxybenzamine have been tried. Calcium channel blockers are also felt to offer some promise.[8] Severe or progressive disease, especially with evidence of gangrene, warrants sympathectomy. This may improve the situation, but 25-40% of patients may develop recurrence of the disease related to the completeness of the sympathectomy, stage of the disease at surgery, and the speed of nerve regeneration. Sympathectomy may also be tried for Raynaud's phenomenon related to other diseases if treatment of the primary disease does not improve the situation. One exception is Raynaud's phenomenon related to scleroderma, which has a dismal response to sympathectomy. It is only minimally helpful in the other "collagen vascular" diseases also. Controversy exists over the correct number of upper thoracic ganglia to remove, and this no doubt contributes to the variability in reported results of sympathectomy for these conditions.

Small vessel diseases include a very large group of disorders of varying etiologies and varying severity. Treatment is primarily medical, particularly in the vasculitides, where steroids, immunosuppressive therapy, and plasmapheresis have proven to offer considerable benefit. The role of surgery lies primarily in diagnostic biopsy in the vasculitides, along with providing angioaccess for plasmapheresis, and in debridement and amputation where appropriate. On occasion sympathectomy may assist management of vasospastic disorders related to the angiitides, as well as in true Raynaud's disease or phenomenon related to other diseases. Another role for surgery relates to the diagnosis and management of proximal occlusive disease that may compound problems caused by distal small vessel disease or may perhaps even be a source of atheroemboli causing progressive distal small vessel occlusion.

As our knowledge of the pathophysiology of these various diseases increases, perhaps we will be able to improve our therapies and reduce the morbidity and mortality related to diseases of the small arteries and veins. ★★★

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SPECIAL ARTICLE

Radiological Seminar CCXL: Case Report: CT Diagnosis of Colon Lipomas

PHILIP E. CRANSTON, M.D.
Jackson, Mississippi

CT BODY SCANNING has been shown to be an excellent modality for the diagnosis of lipomas anywhere in the body. The CT numbers will show the lesion to be definitely benign fat. This is a case report of a colon lipoma definitively diagnosed utilizing CT scanning.

Case Report

This 90-year-old black female was admitted to University Medical Center Hospital for epigastric pain and melena. Endoscopy revealed a pyloric ulcer suspicious for cancer. A barium enema demonstrated a polypoid defect at the hepatic flexure (see Figure 1). A subsequent CT scan demonstrated that the colon lesion was a lipoma, being composed of typical fatty tissue (see Figure 2). There was also demonstrated a mass at the antrum of the stomach consistent with carcinoma. The patient refused any surgery and was discharged.

Figure 1. Polypoid lesion demonstrated by barium enema at hepatic flexure of colon, outlined by arrows.

Discussion

For diagnosis of a colon lipoma by CT scanning, filling the colon with water soluble contrast medium is necessary to adequately outline the lipoma and allow diagnosis. In addition, the contrast medium will outline the colon on the scout view allowing scanning of a particular area as in this case, the hepatic flexure. In a previous report on diagnosing a colon lipoma, it was noted that a gastrografin enema was given to fill the colon.[1] A simpler method for filling the colon with contrast medium is to administer 1 oz. of undiluted gastrografin the night prior to the exam. This is our standard procedure prior to all body scans, and this will completely fill the colon with contrast medium (see Figure 3).

In the past lesions have occasionally been detected by barium enema which appeared to be lipomas, ie, they appeared radiolucent and/or changed shape. Now CT body scanning can be used for definitive diagnosis by showing the lesion to be composed of typical benign fat. For the detection and

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center, Jackson, MS.

Figure 2. Cursor on lipoma with region of interest. Mean CT number minus 109 (− 109) typical of fat.

Figure 3. Scout view demonstrating region of hepatic flexure of colon outlined by contrast medium.

evaluation of the smaller lipomas, the scan section may have to be extra-thin and targeted (magnified) as was done for this patient. ★★★

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The President Speaking

Patient Complaints

Ellis M. Moffitt, M.D.
Jackson, Mississippi

The practice of medicine today faces a competitive dilemma, as I have noted before in this president's page. The ability of physicians to confront this situation centers around an awareness of the factors in the changing environment of medical care.

A recent Gallup poll gives us some idea of one of these factors — changing consumer attitudes. That survey found that 56% of the patients were pleased with the latest encounter with medical care, but 75% felt the cost of that encounter was too high. Another finding was that 58% believe the reason patients do not shop around for a doctor is that they all charge about the same. This indicates that the public does not associate fees charged by doctors with clinical competence.

Patients have three main concerns. In order of frequency they are: (1) physician communication, (2) fees and (3) dissatisfaction with medical office personnel.

Let me start with #3. The front office or, the "hello" place, creates the initial impression. The two best attributes are common sense and basic courtesy. Most patient complaints center around being put on hold too long with a telephone call, failure to listen carefully to the patient's problems, failure to schedule appointments that are convenient to patients, being overaggressive in collections, and employees who are unsympathetic or unfriendly.

The second most common concern of patients is fees. Most physicians in this modern day have excellent business backgrounds, either acquired from the "school of hard knocks" or because they have been well schooled in basic accounting procedures and office management, and consequently most physicians practice good cost accounting methods. In spite of our intense efforts to control our own costs, health care costs have continued to rise. We do have the best health care anywhere in the world and it is available to every citizen in our state and nation. Nationally the cost of health care is lowest in Mississippi, thanks to your concern and concerted efforts to keep it that way. We must continue to work with our patients who are under economic hardships — those who have been terminated from their work because of the recent recession. Remember, Mississippi will be the last to recover from the recession.

Doctor-patient communication is the primary concern of our patients. The number one complaint voiced in most patient surveys

(Continued on page 245)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXV, Number 9

SEPTEMBER 1984

Editing the Hippocratic Oath

I had occasion to attend this year's University Medical Center commencement exercises at the city auditorium (my wife's nephew received his M.D.) and was duly impressed — first by the number and variety of graduates, then the fine figure of the new Chancellor making the address, and of course Rupe Lovelace in his Harvard regalia!

As the seniors stood and recited the Oath of Hippocrates in unison, I felt a deep sense of pride in the school and in Mississippi. As the crowd flowed out on the sidewalk, and in the midst of the festive air, I felt a small twinge down inside, for I suddenly realized that a little editing had occurred on the Oath!

No longer do they swear not to issue a pessary for abortion to their patients as we did. I don't want to get involved in deep ethical or philosophical discussion, but dammit (!) I did feel a twinge! I realize, as my grandchildren constantly advise me, that it's a new day. I guess we'll be all right as long as we keep the Nine Commandments!

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

PRESIDENT SPEAKING

(Continued from page 244)

is that "the doctor did not spend enough time with me." While most patients cannot judge a physician's technical ability, they do know if they have been treated with respect and if the physician is genuinely interested in them and concerned about them as fellow human beings.

There are several ways you can monitor and improve your practice techniques: (1) distribute patient brochures, (2) use questionnaires to identify patient concerns; (3) conduct meetings with office staff to discuss these concerns, and (4) use patient newsletters to improve communication.

All of the above issues must be addressed if we are to be competitive in this changing environment. A trillion dollars is to be spent on health care by 1993. A lot of people other than health care providers are also interested in their share of the health care dollar. One of the latest is Sears, which is looking into providing primary care. Their interest and goal is to be the provider of primary care to 25% of the nation in ten years. Ladies and gentlemen, this translates into 50 billion dollars in 1993. ★★★

LETTERS

SIRS: I would like to answer the issues raised by Dr. Derrick's editorial "I Told You So!" (March issue). Dr. Derrick complained about the "money-grabbing" activities of the average physician as shown by the fact that the average median income for a physician in 1964 was $28,300 and in 1982 it had soared to $99,500!

In 1964 the "average" physician, assuming he had a wife and two children, would have paid $6,417.50 in federal income tax, leaving him with a disposable income of $21,882.50. The same average physician would have paid $35,199 in taxes on an income of $99,500 in 1982, leaving him with a disposable income of $64,301 which is equivalent to $20,634 in 1964 dollars.

Consider, too, the fact that the work week of an average physician is 51.3 hours. Allowing double wages for overtime, this would give an hourly rate of $31.78 for the physician. The average hourly wages in heavy industry such as automobile and steel hover around $20 an hour. But the average industrial worker can start earning after finishing high school; the

average physician has to wait twelve additional years during which time he goes to school, spends up to $100,000 of his own money, and finally emerges $18,000 in debt to start practice at age 30. Further, how many industrial workers does one know who have to be "on call" nights and weekends? And finally how many doctors does one know who can afford the luxury of "calling in sick" Mondays or Fridays up to 20% of the time and still expect to stay in practice?

Now, let me hasten to say that the above has not been written in self-justification since the writer has never been guilty of reaching the "average" income. Like so many other physicians, I too believe in service and charitable work and hope every member of our profession would find it within himself or herself to donate some time to help those who are financially disadvantaged. Such donations, however, should reflect a personal decision and should not be mandated by the society. Every physician has the right to work as hard and for as little as he/she wants; but unless society decides that the vow of austerity should be a prerequisite to entry into the medical profession, let us not denounce those who earn more than some of us think they should.

People enter the field of medicine for various reasons; some are altruistic; others regard it as a profession. Of these, some may be bright, talented and hard-working and may "succeed" at their profession just as a lawyer, writer or musician may succeed at his. I do not know the ENT man referred to in the editorial; I do feel it is unfair to question his ethics and accuse him of sacrificing "many dusky little ear-drums" on "his altar of avarice."

I do not think the report that a certain successful physician earned $185,000 will blast a niche in our crumbling image. For comparison refer to the medico-legal brief reported in the same journal issue where a Florida appellate court decided that $1.5 million was "a reasonable amount of attorney fee" for a single case. The public respects success as long as it is achieved honestly and justly, although the respect is of a different nature than that accorded to a Mother Teresa. Displays of self-flagellation by our profession in such respected forums as the editorial column of the mouthpiece of our organization will not, on the other hand, fail to lower us in the public eye.

K. S. Potnis, M.D.
Vicksburg, MS

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COMMENT

Nuclear Waste Disposal

Don La Grone is to be congratulated for a thoughtful report on the considerations involved in the disposal of nuclear waste in Mississippi. While in substantial agreement with his conclusions, several of the data regarding the health risks of ionizing radiation need to be challenged. This is particularly relevant since similar data is being presented to patients in a brochure sponsored by the MSMA.

That ionizing radiation can produce most types of cancer in animals and humans is unquestioned. Whether exposure to low-dose irradiation can produce the effects cited in the article is a matter of considerable controversy. Since the greatest single source of man-made ionizing radiation exposure in humans is medical irradiation (accounting for about 0.077 rad-per-person-per-year), the medical profession is obligated to carefully consider the epidemiological premise of increased health risk.

La Grone predicts an excess of 100 deaths per million population from leukemia and other cancers as well as 160 genetically damaged children in the first generation from exposure to one rad-per-person. In fact, no study has been done to establish this relationship and a study designed to test a rate of 0.0001 would be practically impossible. To arrive at this rate requires the pooling of various data, ignoring confounding variables, and several assumptions which are in conflict with other published data.[1]

In-utero exposure to radiation has been associated with an increase in relative risk to childhood cancer, but the effect may not be causal.[2] Selection factors or other bias may be operative,[3] otherwise, the absence of this effect of in-utero exposure in A-bomb survivors,[4] the finding of excess risk in white but not black children,[5] the lack of observation of this effect in animals,[6] and the lack of this effect in some studies[7] is difficult to explain.

La Grone cites increased rates of chromosome abnormalities in British dockyard workers exposed to "safe" levels of irradiation, but studies in dockyard workers in this country have concluded that workers are *not* at increased risk of radiation-associated cancer.[1]

The data cited from the leukemia rate in residents of Nevada and Utah in 1957 are also subject to epidemiological criticism. The number of deaths in the group deemed to be at greatest risk was 32 (small for statistical purposes), there was no association between exposure-risk for other childhood cancers, and in point of fact the leukemia rate was not higher than the national average but rather the risk in the low-risk cohort was abnormally low.[8] In the words of the authors of that study, "the mixture of positive, negative, and equivocal results leads us to postulate that ionizing radiation in itself is neither safe nor dangerous."[9]

As a medical association we should support the premise that nuclear waste disposal should be primarily a scientific problem and not a political problem. There are great risks in the transportation and geological storage of nuclear waste, as La Grone correctly points out. The data on salt-dome storage in Mississippi is clearly not in, and the proposal should be opposed.

However, as scientists, we must carefully and impassionately represent the complexity of the risk of ionizing radiation to the public, since we are currently the source of exposure to most of that irradiation. Radiation is not "safe" but failure to keep our perspective of risk-benefit may open a Pandora's box of hysteria in those we serve.

David R. Thomas, M.D.
2500 North State Street
Jackson, MS

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Journal MSMA invites your comments, inquiries, and suggestions. Please address correspondence to the Editors, P.O. Box 5229, Jackson, MS 39216.

Medico-Legal Brief

Court Should Not Have Enjoined Hospital From Expelling MD From Staff Privileges

A trial court erred in permanently enjoining a private, not-for-profit hospital from expelling a physician from staff privileges based on matters presented to an ad hoc committee, an Illinois appellate court ruled.

The hospital administrator requested the credentials committee to take corrective action against the physician. He was charged with attempting to induce labor in a pregnant patient in an effort to convenience himself rather than in the best interests of his patient. The credentials committee met and voted to recommend the expulsion of the physician from staff privileges. He appealed the credentials committee's recommendation, and was given a full hearing before an ad hoc committee selected from the entire medical staff.

Four charges were discussed at that meeting. The charges were (1) that he made entries on a patient's chart and removed an EKG strip from the hospital in violation of hospital rules during a time when he was suspended from admitting patients to the hospital; (2) that during the same period of suspension he admitted a patient to the hospital and participated in the patient's treatment; (3) that he failed to cooperate with the Professional Services Review Organization in four cases; and (4) that he administered a drug to a pregnant patient to induce labor in violation of hospital rules.

The ad hoc committee also recommended expulsion and the board of managers affirmed the recommendation of expulsion.

The physician filed suit seeking an injunction and a trial court awarded him a temporary restraining order. After a hearing the court granted the physician's motion for summary judgment and ordered that the hospital be permanently enjoined from expelling him or from interfering in any way with his staff privileges based on matters presented to the ad hoc committee.

Reversing the decision, the appellate court said that if the hospital followed its procedures in accordance with its by-laws, the trial court should not have interfered with the case at all.

The physician argued that his expulsion was void based on two alleged violations of hospital by-laws. The first violation allegedly occurred when the hospital chief-of-staff sat on the credentials committee that first recommended the physician's expulsion and also sat on the ad hoc committee that reviewed the recommendation. The court noted that the hospital by-laws stated that no staff member who actively participated in the consideration of the adverse recommendation shall be appointed a member of the hearing committee. The appellate court said that the involvement of the chief-of-staff during the credentials committee was not active participation and was not unfair or violative of the by-laws.

The hospital acted within the by-laws by referring the physician's case first to the credentials committee. Review was then properly had before the ad hoc committee of staff members, the court said. That procedure was fundamentally fair. Since there was no violation of the hospital by-laws and no inequitable treatment of the physician, the trial court should not have entered the case.

The trial court's order enjoining the hospital from expelling the physician was reversed. — *Maimon v. Sisters of the Third Order of St. Francis,* 458 N.E. 2d 1317 (Ill.App.Ct., Dec. 30, 1983)

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Health Officials Group Honors Dr. Cobb

State Health Officer Dr. Alton B. Cobb, right, is the 1984 recipient of ASTHO's top honor, the McCormack Award. Alabama State Health Officer Dr. Ira Myers, center, presented the McCormack Award and the Swearingen Award to Rhode Island Department of Health Deputy Director John T. Tierney at the spring meeting of the Association of State and Territorial Health Officials.

Five Appointed To UMC Faculty

The University of Mississippi Medical Center has added five to the School of Medicine faculty for the coming academic session.

Dr. Norman C. Nelson, vice chancellor for health affairs, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

They are Dr. Robert C. Jorden, director of the Division of Emergency Medicine and associate professor of medicine; Dr. David Lionel Bruce, professor of anesthesiology; Dr. Barry Clinton Amyx, assistant professor of psychiatry; Dr. John Albert Lucas III, assistant professor of obstetrics and gynecology; and Dr. Helen Reeves Turner, assistant professor of medicine.

Dr. Jorden was director of emergency medicine at the Denver (Colorado) General Hospital prior to his Medical Center appointment and was a staff physician in the emergency department of Booth Memorial Medical Center in Flushing, New York, from 1976-1978. He holds the M.D. and B.S. from Ohio State University. He completed residency training in surgery at New York University Medical Center and in emergency medicine at Denver General Hospital, St. Anthony Hospital Systems, St. Joseph Hospital.

Dr. Bruce, who holds a joint appointment as professor of nurse anesthesiology in the School of Health Related Professions, holds the M.D. from the University of Illinois College of Medicine. He completed internship at the University of Illinois and residency training at the University of Pennsylvania in 1964. He was professor of anesthesiology at New York University Medical Center prior to his UMC appointment.

Dr. Amyx is a 1973 graduate of Harvard University and earned the M.D. at the University of Kentucky College of Medicine. He also interned at the University of Kentucky Medical Center. He did psychiatry residencies at Johns Hopkins University Hospital and Cherokee Mental Health Institute. He was assistant professor of psychiatry at the University of South Dakota from 1981-1983 and for the past year was director of the division of admissions of the Kalamazoo Regional Psychiatric Hospital in Kalamazoo, Michigan.

Dr. Lucas earned the B.S. at Mississippi College and the M.D. at the University of Alabama School of Medicine in 1974. He completed residency training at UMC in 1978, practiced in Mobile, Alabama, for three years, and went to the Cecil H. and Ida Green Center for Reproductive Biology Sciences, University of Texas Southwestern Medical School, for a postdoctoral fellowship.

Dr. Turner earned the M.D. and the Ph.D. at the Medical Center and the B.S. at Mississippi University for Women. She also completed internship, residency training and a fellowship in infectious diseases at UMC.

JOIN MPAC TODAY

Dr. James C. Waites of Laurel, second from left, was installed as president of the Mississippi Academy of Family Physicians during the MAFP's 36th annual assembly in Biloxi in June. At left is Dr. Peter Hansen, vice president of the American Academy of Family Physicians, who administered the oath of office to other MAFP officers, including, from left, Dr. Eugene Wood of Jackson, president-elect; Dr. Leonard Brandon of Starkville, vice president; Dr. Joe Johnston of Mt. Olive, delegate; and Dr. Walter Rose of Indianola, alternate delegate.

Faculty Promotions Announced at UMC

Three University of Mississippi School of Medicine faculty members reached the rank of professor in promotions announced on July 1 by Dr. Norman C. Nelson, Medical Center vice chancellor for Health affairs and medical school dean.

Dr. Nelson announces the changes in the status following approval by the Board of Trustees, State Institutions of Higher Learning.

Moving up to the rank of professor were Dr. J. Maurice Mahan in psychiatry, Dr. Philip G. Rhodes in pediatrics and Dr. Roger A. Norman in physiology and biophysics.

Dr. Mahan joined the UMC faculty in 1977. He also serves as director of instructional development and evaluation in the division of learning resources. A graduate of Grove City College, he earned his M.S. at Bucknell University and his Ph.D. at the University of Illinois. Prior to coming to Mississippi, Dr. Mahan was on the University of Texas Medical Branch faculty at Galveston.

A graduate of Friends University, Dr. Rhodes earned his M.D. at Kansas University Medical Center and took his residency in pediatrics at Childrens Mercy Hospital in Kansas City, Missouri. The author of more than 70 professional articles, he joined the Medical Center faculty in 1979 following five years on the Missouri faculty. He also serves as chief of the division of newborn medicine at the Medical Center.

Dr. Norman joined the Medical Center faculty in 1974. He earned his baccalaureate and masters degrees at Ole Miss and his Ph.D. in biomedical engineering at the Medical Center. Dr. Norman is the author or co-author of nearly 30 scientific publications. He has held a National Defense Education Act fellowship and a predoctoral fellowship from the National Institutes of Health.

School of Medicine faculty promoted to the rank of associate professor in July were Dr. Lodovico Balducci and Dr. Stanley W. Chapman, medicine; Dr. Ching-Jygh Chen and Dr. James W. Maher, surgery; Dr. Bennie R. Clower, neurosurgery; Dr. Rodney Meeks and Dr. Michel E. Rivlin, obstetrics-gynecology; Dr. Rameshkumar B. Patel, radiology; and Dr. Ellie T. Sturgis and Dr. Jeffrey Webster, psychiatry (psychology).

Those promoted to the rank of associate professor in the centerwide faculty were Dr. Marvin Cuchens, microbiology; Dr. Jerry M. Farley and Dr. Madge Pfaffman, pharmacology; and Dr. Robert E. Lewis and Dr. Edward E. Smith, pathology.

School of Medicine faculty promoted to the rank of assistant professor were Dr. Andrew S. Anfanger, medicine; Dr. Stephen Rapp, psychiatry (psychology); and Dr. David Schlundt, psychiatry.

Dr. Nelson also announced the promotions of six clinical faculty members. They included Dr. George Ball of Jackson, Dr. Swan B. Burrus of Tupelo and Dr. Richard S. Hollis of Amory to clinical professor of obstetrics and gynecology; and Dr. Thomas C. Fenter of Jackson, Dr. Lucas O. Platt of Tupelo and Dr. Joe R. Ross of Jackson to clinical assistant professor of surgery (urology).

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POSTGRADUATE CALENDAR

FUTURE CALENDAR

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Oct. 19
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Oct. 19-20
Annual Pediatric Meeting
University Medical Center, Jackson

Oct. 23
Thoracic Society Annual Meeting
University Medical Center, Jackson

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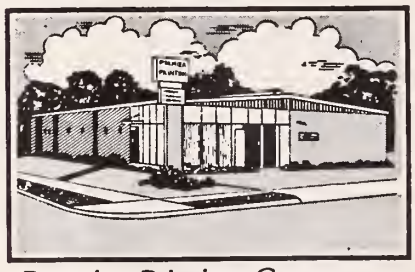

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Medical Genetics Course Offered This Month

A mini-residency in medical genetics will be conducted September 21 and 22 at Singing River Hospital in Pascagoula.

Sponsors are the Department of Medical Genetics of the University of South Alabama at Mobile and Singing River Hospital. The course is accredited for 10 hours Category 1, AMA.

For information, contact the administrator's office, Singing River Hospital, 2809 Denny Avenue, Pascagoula, MS 39567 (601) 938-5005.

Medical Center Schedules ICD-9-CM Coding Workshop

The University of Mississippi Medical Center will present a basic ICD-9-CM coding workshop October 4-5 at the Medical Center in Jackson. The course is designed to assist medical record personnel and coding clerks who have no formal training in or little professional experience with this system. Rules particular to the various anatomic systems will be covered. Sponsors are the UMC School of Health Related Professions Department of Medical Record Administration and the Medical Center Division of Continuing Health Professional Education.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216; (601) 987-4914.

PERSONALS

James Achord of UMC was on the faculty for a recent continuing education program at Gulf Coast Community Hospital in Biloxi.

Edward J. Bass has associated with Medical Group of Hattiesburg, P.A., 101 Asbury Circle, for the practice of internal medicine and cardiology.

Jim M. Brock of McComb announces the association of Jim M. Brock, Jr., for the practice of dermatology.

Ronald A. Bullock has associated with Hattiesburg Clinic, P.A., 415 South 28th Avenue, for the practice of family medicine.

C. Duane Burgess has returned to Hattiesburg and resumed the practice of psychiatry with offices at 2910 Mamie Street.

Richard A. Conn has associated with Hattiesburg Clinic, P.A., 415 South 28th Avenue, for the practice of orthopedic surgery.

Ching-Jygh Chen of UMC was guest speaker at the 13th congress and scientific meeting of the Chinese Medical Association in Taipei, Taiwan, in July.

Wallace Conerly of UMC was speaker at meetings of the Belzoni Rotary Club and the Scott County Alumni Chapter of the University of Mississippi Alumni Association.

Frank H. Dailey announces the opening of his office for the practice of internal medicine at 2500 5th Street North in Columbus.

James Dolan announces the opening of his office for general and family practice at Pass Road Medical Plaza in Gulfport.

William K. Erly announces the opening of his family practice at Kemper County Medical Center in DeKalb, in association with Prentiss Keyes, Jim Smith, and W. W. Oliphant.

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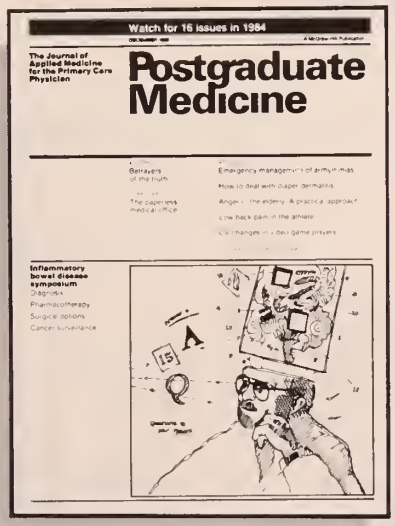

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ROBERT M. EVANS announces the opening of his practice of internal medicine and endocrinology at 768 Lakeland Drive in Jackson, in association with JOHN D. WOFFORD and JOHN D. WOFFORD, JR.

J. KEN GRAFTON has associated with the Westridge Family Clinic, 307 South 13th Avenue in Laurel, for the practice of family medicine.

T. DAVID GRIFFIN announces the opening of Vardaman Medical Clinic, Highway 8 East, for the practice of family medicine.

WILLIAM H. GULLUNG, III, of Hattiesburg announces the association of STEVEN L. CONERLY for the practice of dermatology.

CHARLES E. HALL announces his association with the Medical Clinic, P.A., 746 Manship Street in Jackson, for the practice of gastroenterology.

MICHAEL J. HARKNESS announces the opening of his office for the practice of pediatrics at 918 Sumrall Road in Columbia.

JAMES KENNETH HARVEY has associated with Internal Medicine Associates of Tupelo, 845 South Madison Street, for the practice of internal medicine.

W. B. HUNT of Grenada received the John B. Howell Memorial Award during the annual meeting of the Mississippi Academy of Family Physicians.

THOMAS A. IRELAND has associated with McComb Children's Clinic, 300 Rawls Drive, for the practice of pediatrics.

JOHN JACKSON of UMC presented a paper and served as moderator for a session during the Southern Genetics Group meeting in Pensacola Beach, Florida, in July.

PAMELA L. JETT of Vicksburg has been named a diplomate of the American Board of Pathology.

JOHN KAPP of UMC presented a paper at the joint meeting of the Mississippi and Alabama Neurosurgical Society in Point Clear, Alabama.

ROY B. KELLUM has associated with JOEL G. PAYNE, JR. and EARL T. STUBBLEFIELD for the practice of obstetrics and gynecology.

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EDWARD LOWICKI of Jackson has been appointed by Governor Bill Allain to the Mississippi Council on Aging.

FRANK MCCUNE announces the opening of his office for the practice of surgery at 624 East Peace Street in Canton.

GREGORY W. MERRITT has associated with the Pediatric Clinic, P.A., 1101 South 28th Avenue in Hattiesburg, for the practice of pediatrics.

WILLIAM C. NICHOLAS of UMC was in McComb to establish a new affiliate of the American Diabetes Association and presented talks on diabetes at Greenwood Leflore Hospital in Greenwood and Humana Hospital in Jackson.

JAMES MARTIN of UMC was grand rounds speaker at the University of Tennessee in Memphis in July.

JOHN MORRISON of UMC was speaker for grand rounds at Emory University in Atlanta in July.

ELLIS H. O'NEAL announces the opening of his practice of family medicine at 129 East Starling Street in Greenville.

OWEN PHILLIPS has associated with JACK C. HOOVER, THOMAS R. SINGLEY, and BRUNER B. BOSIO of Pascagoula for the practice of obstetrics and gynecology.

THOMAS V. ROE has associated with the Segars Clinic, P.A., 1507 West Quitman Street in Iuka, for the practice of general medicine.

DAVE A. RUSSELL has associated with Meridian Medical Associates, P.A., 1525 22nd Avenue in Meridian, for the practice of cardiology.

RICKY G. RUSSELL announces the opening of his office for the practice of ophthalmology at UMC's McBryde Building in Jackson.

KEITH P. SMITH announces the opening of his office for the practice of general and vascular surgery at 140 Jefferson Davis Boulevard in Natchez.

G. O. SPENCER, JR. of Columbus announces the association of THOMAS L. VINSON for the practice of general, chest and vascular surgery.

JERRY L. STENNETT has associated with Columbus Surgery Associates for the practice of general, thoracic and vascular surgery.

MARTHA LOUISE STEVENS announces the opening of her office at 912 Sumrall Road in Columbia, for the practice of pediatrics.

MICHAEL O. STODARD announces his association with CHARLES M. WEBBER of Madison for the practice of family medicine.

THOMAS L. SWEAT of Corinth has been appointed to the Mississippi Health Care Commission.

STEPHEN W. TARTT has associated with Medical Arts Surgical Group, 2111 14th Street in Meridian, for the practice of general and peripheral vascular surgery.

MAX ROBERT TAYLOR has associated with Internal Medical Associates of Tupelo for the practice of internal medicine and infectious disease.

J. TATE THIGPEN of Jackson received the first annual J. Tate Thigpen Award presented by the American Red Cross Central Mississippi Chapter.

PLEZ TINSLEY has associated with DON DAVIS of Meridian for the practice of ear, nose and throat and head and neck surgery.

DAVID E. ULMER has associated with WILLIAM GILLESPIE of Columbus for the practice of ophthalmology.

INDIRA VEERISETTY announces the opening of Madison-Ridgeland Medical Clinic, Highway 51 North, Ridgeland, for the practice of general and internal medicine.

JAMES C. WAITES of Laurel was installed as president of the Mississippi Academy of Family Physicians at the recent annual meeting in Biloxi.

CLARENCE B. WATRIDGE has associated with DONALD F. DOHN and JOHN J. MCCLOSKEY of Pascagoula for the practice of neurological surgery.

JULIAN WIENER of Jackson announces his retirement from the practice of urology.

—Next Month in Journal MSMA—

"Temporal Arteritis"

"Short-Term and Long-Term Effects Of a High Blood Pressure Intervention Program"

"Severe Neutropenia and Infectious Mononucleosis"

Report of the MSMA Board of Trustees Summer Meeting

Roche salutes
the history of Mississippi medicine

SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.[1]

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap 5, in Lee RV, Eimerl S *et al*: *The Physician* New York, Life Science Library, Time Inc , 1967, pp 107-109

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When the history reveals mixed depression and anxiety...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,[1] Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl/Roche), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs which has been associated with tardive dyskinesia.

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
  Middle insomnia—87%
  Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: **1.** Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jorvik ME; New York, Appleton-Century-Crofts, 1977, p. 316 **2.** Feighner JP *et al*: *Psychopharmacology 61*: 217-229, Mar 1979 **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® Tablets ⓝ Tranquilizer–Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving)

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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OTOLARYNGOLOGIST currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

BOARD CERTIFIED head and neck surgeon now finishing facial plastic surgery fellowship. Desire opportunity or association in which to develop facial plastic and reconstructive surgery practice. Contact Donn R. Chatham, M.D., 1516 South 20th St., Birmingham, AL 35205; (205) 933-8799 or 871-0429.

Physicians Wanted

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN. Ideal practice opportunity in thriving central Mississippi community of 5,000. Surrounding trade area has 25,000 population base. Excellent opportunity for OB practice if desired. Situated within one hour's drive of Jackson. Reply to Box B, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

NEEDED: OBG — FP — IM — clinic. Salary plus partnership. Call Mike Jenkins, RH Medical Group, 12651 Briar Forest, #180, Houston, TX 77077; (713) 496-7777.

EMERGENCY PHYSICIAN, North Mississippi Medical Center, 600+ beds, Mississippi's largest, approx. 8000 sq. ft. emergency facility, over 30,000 visits/yr., tertiary referral of trauma from the surrounding area, hospital based ambulance service, base hospital medical control, paramedic school, good community, excellent schools, 100 miles to Memphis, 120 to Birmingham. Administrative responsibility, guarantee $110,000/yr. for 45 hour/week, fee-for-service basis, paid malpractice. Contact Alan Brown, M.D. at (601) 841-3000 or (601) 841-2150.

BOARD CERTIFIED or board eligible pediatrician to join three-pediatrician practice. Senior partner preparing to retire. Prefer pediatrician with extra training or interest in neonatology. Immediate opening. Salary with early partnership. Send resume to Dr. William B. Simmons, 2115 14th Street, Meridian, MS 39301; (601) 693-2441.

OB/GYN — needed in Middle Tennessee to be affiliated with 100+ bed hospital with intensive care unit and emergency room, limited coverage can be provided. Must be Board eligible or certified. Attractive financial package including guaranteed minimum collections, assistance with office rent and expense, moving and interview expenses paid. Wide range of recreational activities available in the immediate area. Reply to Box M, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

ORTHOPEDIC SURGEON — needed in Middle Tennessee, to be affiliated with a 100+ bed hospital with intensive care unit and emergency room, limited coverage can be provided. Must be Board eligible or certified. Attractive financial package including guaranteed minimum collections, assistance with office rent and expense, moving and interview expenses paid. Wide range of recreational activities available in the immediate area. Reply to Box L, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

Family Practitioner for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

Fully Equipped ob-gyn clinic available for immediate occupancy. Trade area of approximately 50,000 persons; modern hospital; no other obstetricians in immediate area. Contact Mr. James Townsend, Administrator, Bolivar County Hospital, Cleveland, MS 38732, or call (601) 846-2550.

Community seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

Family Practitioner wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

Family Practitioner or Internist wanted in Union, Mississippi. Seven referring GPs; attractive guarantee; office space furnished. Contact Margaret Muse or John Bradshaw, Laird Hospital, Union, MS 39365; (601) 774-8214.

Family practitioner wanted for west central Mississippi town in Hinds County, population 1,000 — draws trade from four counties; less than 30 miles to hospitals; good highways. Facilities can be provided if desired. Call (601) 885-8718 or write to Mayor James Keith, P.O. Drawer K, Utica, MS 39175.

Community seeks general surgeon. Contact Mr. William E. Rutledge, Administrator, Tishomingo County Hospital, Iuka, MS 38852.

53-year-old ABFP, on Mississippi Gulf Coast, needs board certified/qualified family practitioner as associate or partner. Financial arrangements negotiable. Please send information to Box K c/o Journal MSMA.

Consulting Physicians. Board eligible orthopedic and psychiatric consultants needed 25-30 hours per week for evaluation of Social Security disability claims. Positions available immediately. For additional information, please call Deborah Warriner, Medical Staff Coordinator, Disability Determination Services, (601) 923-2153.

Physicians needed in all specialties, particularly Medicine, Obstetrics, Orthopedics. Practice opportunities throughout the country, with a strong base in the southern states. Recruiter is an R.N. certified in Nursing Administration, and understands physicians' goals. Strictest confidence. No fee to physician. Contact Georgette Sloan, Action Line, Inc., (504) 889-0306.

Surgeon, Internal Medicine, OB/GYN, Pediatrician (Board eligible/certified) needed in progressive Northeast MS town of approximately 8,000 with 20,000-30,000 trade area on Tenn-Tom Waterway. Modern hospital; nearby regional medical centers. Excellent boating, fishing, hunting, other outdoor activities. For further information, contact Administration, AMCH, P. O. Box 747, Aberdeen, MS 39730; (601) 369-2455.

Emergency Medicine. Immediate full-time positions available in emergency departments located in central and south Mississippi. Excellent benefits package. Quality rural and metropolitan hospitals. Part-time positions are also available. For a unqiue career opportunity, respond in confidence to: Mississippi Emergency Association, P. A., 1755 Lelia Drive, Suite 100, Jackson, Mississippi 39216-4883 or call Dr. Jim Heflin, Director of Physician Recruitment at (601) 366-6503.

PHYSICIANS NEEDED

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact one of the following Medical Relations Officers: Henry Klar (Ext. 2276), Martina Mayfield (Ext. 2227), or Neil McGaughey (Ext. 2249).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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ESTABLISHED GENERAL PRACTICE for sale. One-half of all brick building for general family practice. Located in county seat of 5,000 with a trade area of 30,000. Completely furnished 3400 square foot building. Emergency, radiograph, laboratory and all instruments included. Associate located in other half of building. Owner now deceased. Richard B. Akin, 331 W. Gallatin, Hazlehurst, MS 39083; (601) 894-1634.

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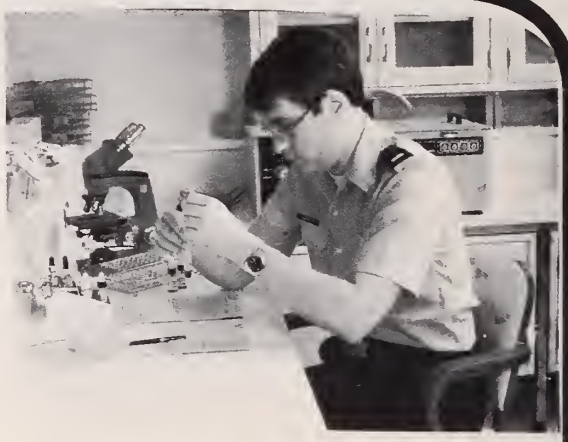

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Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with aopropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.*g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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October 1984

JOURNAL of the MISSISSIPPI State Medical Association

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October 1984, Volume XXV, Number 10

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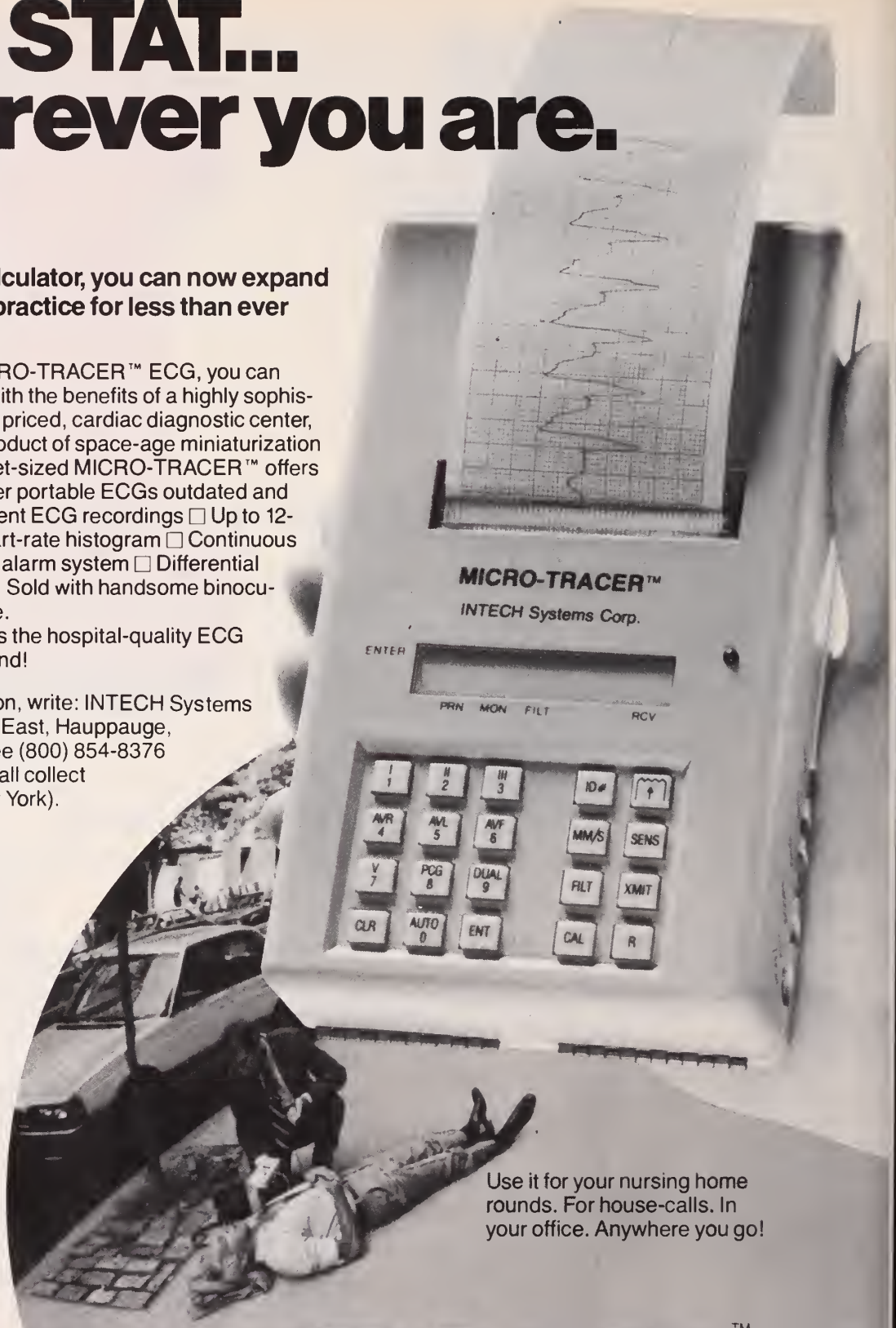

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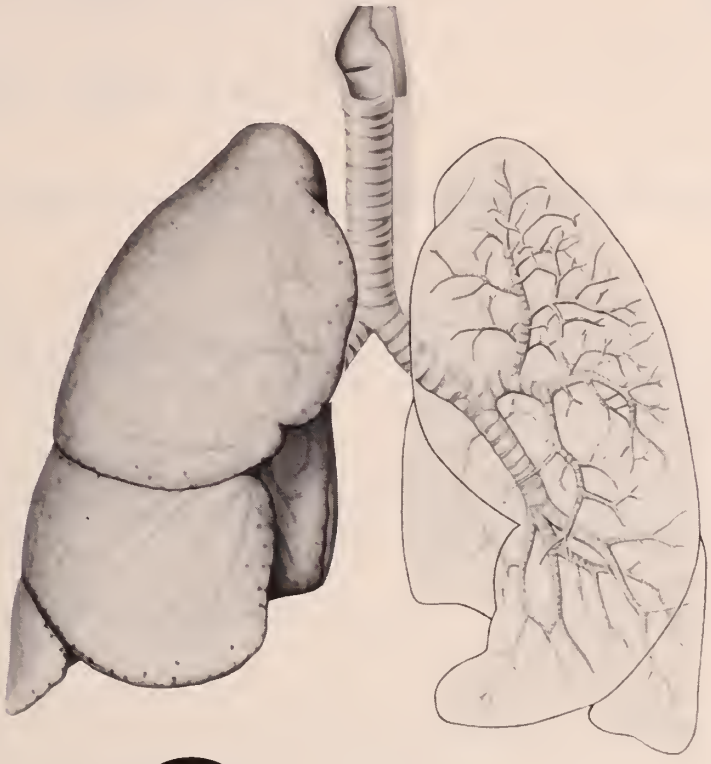

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Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal: symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity: reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other: effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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NEWSLETTER

October 1984

Dear Doctor:

Two new services will soon be available to members of MSMA. The Board of Trustees has approved plans for the association to sponsor a computerized medical information system for physicians' offices and a group purchase plan for medical office supplies. The computer services program will be introduced at the 117th Annual Session next May. The group purchase plan, already in place, is expected to provide up to 30-40% savings on medical supplies. Members who would like information about the plan may call or write to the headquarters office.

> Another new project for MSMA, approved by the House of Delegates and initiated by the Board of Trustees, is a $1.7 million expansion and renovation of the headquarters building. Plans call for groundbreaking in March 1985. Details about the construction project will be announced in December.

Concerns about availability, accessibility and delivery of medical care to Medicare beneficiaries has prompted the AMA to file a lawsuit challenging the constitutionality of provisions of the Medicare amendments passed with the Deficit Reduction Act of 1984. The AMA contends that the establishment of categories of "participating" and "nonparticipating" physicians denies Medicare beneficiaries the ability to select the physician from whom they will receive care. The mandated restrictive fee schedules for clinical laboratories is seen as depriving Medicare beneficiaries and others of complete medical services by promoting the reduction of those services, particularly in small and rural communities.

Drug therapies for glaucoma, urinary tract infections and tuberculosis are among the 21 new Patient Medication Instruction (PMI) sheets published by the American Medical Association. The new sheets bring to 81 the number of drugs and drug classes in the PMI series, designed to help physicians communicate drug information to their patients at the time a prescription is written. For order information, contact PMI Order Dept., AMA, P.O. Box 52, Rolling Meadows, IL 60008.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

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Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

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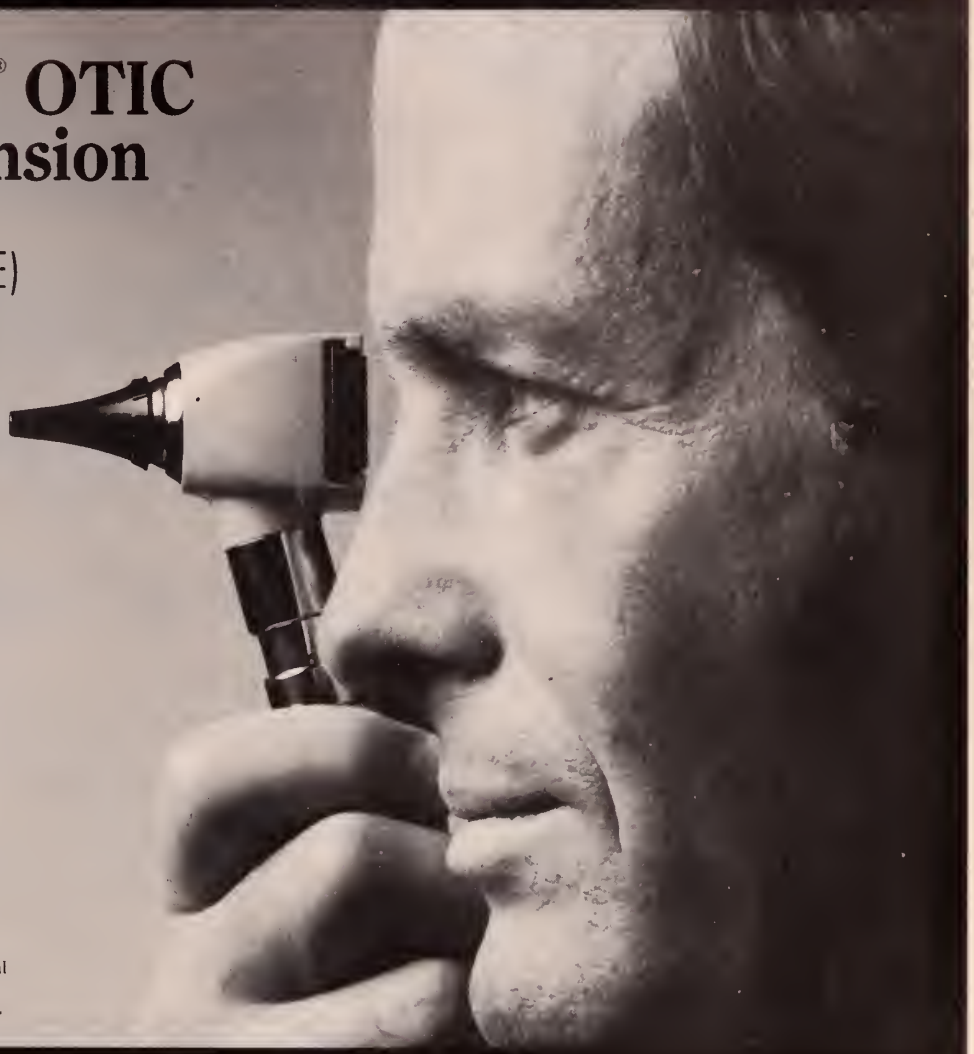
Total ears	107
Responders	104 (97.2%)
Combined suspension and solution	
Total ears	200
Responders	195 (97.5%)

Adapted from Cassisi et al.[1]

REFERENCE:
1. Cassisi N, Cohn A, Davidson T, et al: Diffuse otitis externa: Clinical and microbiologic findings in the course of a multicenter study on a new otic solution. *Ann Otol Rhinol Laryngol* 86(suppl 39, pt 3):1-16, 1977.



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ations: For the treatment of superficial bacterial infections of the external ɔry canal caused by organisms susceptible to the action of the antibiotics, ɔr the treatment of infections of mastoidectomy and fenestration cavities ɜd by organisms susceptible to the antibiotics.
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ations: For the treatment of superficial bacterial infections of the external auditory canal ɜd by organisms susceptible to the action of the antibiotics.
autions: This drug should be used with care when the integrity of the tympanic membrane ɥuestion because of the possibility of ototoxicity caused by neomycin.
rse Reactions: Stinging and burning have been reported when this drug has gained access ' middle ear.
raindications, Warnings, Precautions and Adverse Reactions Common to Both ucts
raindications: These products are contraindicated in those individuals who have shown sensitivity to any of the components, and in herpes simplex, vaccinia and varicella.

Warnings: As with other antibiotic preparations, prolonged treatment may result in overgrowth of nonsusceptible organisms and fungi. If the infection is not improved after one week, cultures and susceptibility tests should be repeated to verify the identity of the organism and to determine whether therapy should be changed.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, such as chronic otitis externa, it should be borne in mind that the skin in these conditions is more liable than is normal skin to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

Precautions: If sensitization or irritation occurs, medication should be discontinued promptly. Patients who prefer to warm the medication before using should be cautioned against heating the solution above body temperature, in order to avoid loss of potency.

Treatment should not be continued for longer than ten days. Allergic cross-reactions may occur which could prevent the use of any or all of the following antibiotics for the treatment of future infections: kanamycin, paromomycin, streptomycin, and possibly gentamicin.

Adverse Reactions: Neomycin is a not uncommon cutaneous sensitizer. There are articles in the current literature that indicate an increase in the prevalence of persons sensitive to neomycin.

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DATELINE

Teenage Suicide Is Program Topic

Jackson, MS - Jackson Mental Health Association and Riverside Hospital are sponsoring a special program on the subject of teenage suicide on Tuesday, October 23 at 7:00 p.m. at the R & D Center's ETV auditorium. Dr. Thais Brown, family physician of Total Life Clinic, will be the moderator. For more information contact Dr. Brown at 366-4475 or Lynn Kelly at Jackson Mental Health Association (948-6190).

Health Department Acting As NHSC Coordinator

Jackson, MS - The State Department of Health, under a contract with the U. S. Public Health Service, has been coordinating placement and management of National Health Service Corps (NHSC) assignees in Mississippi. The contract was established to improve delivery of health care in the state by placing NHSC members, mostly primary care physicians, in designated rural and urban health manpower shortage areas.

Continued Monitoring Of DRG and PRO Programs

Chicago, IL - The AMA will continue to monitor implementation of the DRG and PRO programs. Currently AMA is surveying hospital medical staffs across the country for assessments, pro or con, of the prospective pricing system, and will seek needed modifications. The AMA notes that PROs and DRGs, with their emphasis on minimizing utilization of hospital services, could result in more professional liability suits.

1985 Awards for Hypertension Control

Washington, DC - Nominations are now being accepted by the National Conference on High Blood Pressure Control for its 1985 awards program. Individuals and organizations will be honored for outstanding contributions to high blood pressure control. Nominees must meet seven criteria. For nomination forms and information, contact NCHBPC, 2121 Wisconsin Ave., N.W., Washington, DC 20007; (202) 944-3176.

Book Helps Children Avoid Sexual Abuse

Chicago, IL - A new AMA publication provides information that physicians, parents and teachers can use to help children avoid molestation and sexual abuse. "Sex Talk for a Safe Child" is a coloring-book-style, "read aloud" book designed to teach children about both healthy and "mixed up" sexuality. The book is available from $3.00 from AMA's Order Dept. OP-234, P.O. Box 10946, Chicago, IL 60610.

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Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets, use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

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Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation, see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown*

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under "*Probable Causal Relationship (PCR)*" if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "*Causal Relationship Unknown*" if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

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ORIGINAL PAPERS

Temporal Arteritis: Case and Review

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Jackson, Mississippi

TEMPORAL ARTERITIS is a disease of the elderly characterized by a myriad of presenting symptoms. As in the case reported in this article, the initial clinical characteristics may not be "classic": confusion, sore throat, acute hearing loss, etc. The typical patient has temporal headache and/or palpable tenderness over the temporal artery, an elevated erythrocyte sedimentation rate (usually greater than 40 mm/hr by the Westergren technique), may have the muscle pain, weakness, and arthralgias of the associated diagnosis polymyalgia rheumatica, and shows dramatic improvement with steroids. A high index of suspicion (in elderly patients) combined with a knowledge of the protean manifestations of temporal arteritis and a probing history make a missed diagnosis less likely.

Case Report

An 81-year-old black man was admitted to the hospital with confusion. There had been a gradual decline in mental acuity over a one week period of time culminating in frank confusion and disorientation. He had complained of a headache prior to this but admitted only to a mild headache at the time of admission. The temperature was 101° F (38.3° C), pulse 96, respirations 16, blood pressure 178/100. He was oriented to personal identity but not oriented to situation, place, and time. There was no meningismus and no temporal artery tenderness. The neurological examination and the remainder of the physical examination were completely normal. The serum creatinine was 1.3, random glucose 132, potassium 4.5, sodium 136, bicarbonate 32, calcium 9, SGOT 40. The CBC was normal with a WBC of 8,600 and normal differential. Chest x-ray was normal. Blood cultures (two) were negative. An LP revealed normal glucose, protein, and 3 lymphocytes with negative gram stain, cytology, and culture. The ESR (Westergren) was 55 mm/hr and on repeat 52 mm/hr. CT scan of the head was normal (without contrast). Right temporal artery tenderness was elicited on followup examination. Right temporal artery biopsy with a 1.5 cm segment taken revealed "degenerative changes with inflammation of the wall of the blood vessel, abundant lymphoid cells but no giant cells, and vasculitis involving small blood vessels along the periphery . . . consistent with temporal arteritis."

The patient began taking prednisone 60 mg daily, and dramatic improvements in his sensorium, headache, and temporal artery tenderness were noted within 24 hours. He has had a waxing and waning course as an outpatient but flare-ups have responded to temporary increases in his prednisone. The ESR has been as low as 3 mm/hr on 20 mg of prednisone daily.

Discussion

Temporal arteritis is rare in black people. However, no difference in presentation, response to treatment, or clinical course has been noted. Familial clustering of cases has suggested that genetic as well as immunologic factors are important.[2]

A recent study has revealed an overall average annual incidence of 11.7 per 100,000 persons aged 50 and older, and a prevalence of 133 per 100,000 persons aged 50 and more. Temporal arteritis is rare under age 50 and occurs more frequently in those over age 70. Women are affected nearly twice as often as men, and most cases involve persons of European ancestry.[3]

Dr. Woodliff is engaged in the private practice of internal medicine in Jackson, MS.

The onset of the illness may be abrupt or insidious. Most patients present with a headache usually localized to the temporal area, palpable tenderness over the temporal artery, and may have vague complaints of myalgias and arthralgias (polymyalgia rheumatica). It is important to note that headache may be absent in as many as 40 percent of cases. The disease was first described by Hutchinson in 1890 in an octogenarian with inflamed tender temporal arteries that prevented him from wearing a hat. Probably the most striking aspect of temporal arteritis is the variability of symptoms and clinical presentations. Constitutional manifestations such as malaise, fatigue, and weight loss are common and may be the only findings. Fever of unknown origin is another common presentation. Jaw claudication, due to progressive facial artery occlusion, is an almost pathognomonic feature often described as weakness or fatigue after talking or chewing which disappears when these activities are stopped; this jaw claudication must be distinguished from the jaw weakness and fatigue which may occur in myasthenia gravis. Disorders of the temporomandibular joint may also present confusing similarities.

The less common symptoms in the absence of typical findings may pose a challenge. Psychosis, depression, and confusion have all been described in temporal arteritis. Facial neuralgia, blurred vision, vertigo, diplopia, ptosis, amaurosis fugax, acute hearing loss and sore throat (or deep nasopharyngeal pain) all may bewilder the clinician if temporal arteritis is not suspected. The duration of symptoms before diagnosis ranges from less than one month to 11 months. Important physical findings in addition to tender temporal artery are oculomotor ophthalmoplegia evidenced by diplopia or ptosis, visual field defects, papilledema, central retinal artery occlusion, arterial bruits, fever, glossitis, and rarely gangrene or necrosis of the tongue or scalp.

Histologic changes occur in three distinct patterns: (1) The "classic" presentation is characterized by giant cells; the area of major involvement is the media of the artery with smooth muscle necrosis, and sometimes destruction of the internal elastic membrane. (2) The nonspecific inflammatory reaction involves the entire breadth of the arterial wall with infiltration of neutrophils, lymphocytes, and eosinophils. (3) Intimal fibrosis can take place without severe alteration of either media or internal elastic membrane and the vessel is occluded with an acellular fibrous tissue. The classic features of temporal arteritis result from inflammation and gradual occlusion of branches of the carotid and vertebral arteries. "Skip lesions" are isolated areas of normal histology along the course of an artery with active arteritis. The Mayo Clinic reported a series of 60 patients of whom 28% had definite skip lesions.[4] To counter the problem of skip lesions most investigators recommend the removal of a 4 to 6 cm arterial segment. Arterial biopsy is a simple surgical procedure with infrequent complications. Arterial biopsy represents the only method for identifying patients with polymyalgia rheumatica who harbor occult temporal arteritis. Unilateral biopsy is inconclusive if findings are normal and contralateral biopsy should be done if the clinical suspicion warrants.

SYMPTOMS OF TEMPORAL ARTERITIS

Major symptoms
Headache
Polymyalgia rheumatica (or nonspecific arthralgias, myalgias)
Jaw claudication
Other constitutional symptoms
Diaphoresis
Anorexia
Malaise
Neurologic, ophthalmologic symptoms
Depression
Facial neuralgia
Blurred vision
Confusion
Amaurosis fugax
Diplopia/Ptosis
Visual field deficits
Uncommon
Vertigo
Acute hearing loss
Sore throat/deep nasopharyngeal pain

The erythrocyte sedimentation rate (ESR) is the most helpful laboratory test in the evaluation of temporal arteritis and is markedly elevated in virtually all patients. The disease has been documented by biopsy in a few patients with a normal or mildly elevated ESR. Most experts feel that arterial biopsy should not be deferred because of a normal ESR if other suggestive historic or clinical features exist. The test is also very useful in monitoring therapy — one attempts to maintain an erythrocyte sedimentation rate of 20mm/hour or less and can usually correlate exacerbations of the disease with an increase in ESR. Other less useful laboratory abnormalities are normochromic-normocytic anemia, elevated alkaline phosphatase, hepatocellular dysfunction and elevated alpha 2 and beta globulins.

The most feared complication of temporal arteritis is blindness. It may appear abruptly but in most cases is preceded by several days or weeks of episodic visual loss or headaches. Blindness is usually

irreversible and is caused by ischemic optic neuritis resulting from occlusion of the posterior ciliary and ophthalmic arteries. If blindness occurs in one eye, the other will be similarly affected within days or weeks in 25% of cases unless treatment is given. "Occult" temporal arteritis is a variant whose presenting complaint is blindness, unheralded by other symptoms. Visual loss may be followed by slight papilledema or a normal funduscopic exam for 24-48 hours. Transient ophthalmoplegias result from ischemia(s) of cranial nerves III, IV, and VI. Oculomotor ophthalmoplegia, evidenced by diplopia or ptosis may be an important clue heralding more serious eye involvement. Visual field defects with sector cuts, central scotomata and peripheral constriction can occur.

Corticosteroids are the drug of choice for temporal arteritis. The underlying mechanism of the disease is probably not altered since persistent evidence of arteritis can be found after prolonged therapy in some cases. In patients in whom the clinical impression of temporal arteritis is strong, prednisone can be started immediately and a temporal artery biopsy can be obtained the following day. Corticosteroids quiet the clinical symptoms quickly, normalize the ESR and prevent further visual deterioration. Visual loss has been improved in some patients with high-dose steroid regimens, but most reports view this as an irreversible sequela.[2] Initial therapy with 60 to 80mg of prednisone daily controls the arteritis. Rapid diminution in symptoms within 48 to 72 hours precedes changes in the ESR. Alternate-day steroid therapy has been shown to be less efficacious and should not be used.[7] Maintenance therapy should be the minimum level of daily steroid necessary to keep the patient asymptomatic and the ESR normal (less than 20mm/hour). Reduction of 10% of the total daily dose can be accomplished at weekly intervals until this level is determined. Once the total daily dosage is less than 10mg, monthly tapering by 1 mg per day can be instituted. Corticosteroids can be discontinued in most patients within two years. After a patient has remained asymptomatic for one month or longer off corticosteroids, further relapses are infrequent. ★★★

926 North Street (39202)

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Pneumopyopericardium Complicating Gastric Cancer

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PNEUMOPERICARDIUM (or pneumopyopericardium) is a rare condition which is usually fatal. In a review of the literature from 1831 to 1931, Shackleford found 76 cases and reported one additional case of pneumopericardium.[1] In 1971 Cramm and Robison found 130 additional cases dealing with pneumopericardium. Of these initial 206 cases reported, only 7 cases of pneumopericardium were associated with gastric cancer.[2] A review of the recent literature revealed approximately 12 cases dealing with pneumopericardium and no additional cases associated with gastric cancer.

The case report that follows describes a pneumopyopericardium complicating extensive gastric adenocarcinoma.

Case Report

E. M. was a 70-year-old black man who presented to the admissions office of the VA Medical Center, Jackson, Mississippi, on November 9, 1982, with a chief complaint of dyspnea. He was an extremely poor historian; however, he complained of vague chest pain and "just not feeling good." There was a history of subjective fever for one month which was not associated with night sweats or chills.

His history was significant in that he had adenocarcinoma of the stomach for which he had undergone a gastrectomy in November 1981. At surgery extensive local invasion was noted with involvement of the left lobe of the liver. He refused chemotherapy until September 1982, when a repeat gastroscopy revealed local recurrence. A CT of the abdomen revealed enlarged para-aortic nodes. He received one course of 5 FU, adriamycin, and mitomycin, and then was lost to follow-up until he presented to the admitting physician on November 9, 1982.

Physical examination revealed a cachectic black man in mild respiratory distress. His blood pressure was 130/90 with no significant pulsus paradoxus; respiratory rate was 22; pulse was 96; and his temperature was 36.1° C (97.0° F). Neck veins were not abnormally distended. His skin was dry with decreased turgor. Cardiovascular examination revealed an irregularly-irregular rhythm but no other significant findings (specifically no rub). His lungs were clear, and there was no peripheral edema. The liver was not enlarged.

A CBC on admission revealed a hematocrit of 35% and a WBC of 10,800 with 93% neutrophils. Platelets were adequate. Arterial blood gases were normal.

The chest x-ray (see Figure 1) was impressive in that the cardiac diameter had increased from 12 centimeters to 17 centimeters since a chest x-ray taken in July of 1982. On the lateral chest film (see Figure 2), an obvious air-fluid level was present and appeared to be in the pericardial space. The peripheral lung fields were clear. The EKG suggested pericarditis with ST elevation in leads 1, 2, 3, AVF, V4, V5, and V6. Right atrial enlargement was noted. A 2-D echo shortly after admission revealed a modest pericardial effusion. A CT of his chest (see Figure 3) revealed multiple air-fluid levels in the pericardial space. A meglumine diatrizoate swallow on the day of admission failed to reveal a direct communication from the esophagus or stomach to the pericardial space.

The impression at that time was purulent pericarditis with an enteric-pericardial space fistula (undemonstrated) without evidence of acute tamponade. Surgery was consulted for a subxyphoid pericardiotomy with biopsy and tube drainage. Three hundred milliters of cloudy fluid were drained. The pericardial biopsy and cytology were negative for malignancy. A gram stain of the fluid revealed gram positive cocci. The patient was started on penicillin and gentamicin. Subsequent cultures revealed seven organisms, anaerobic and aerobic.

From the Department of Medicine, Division of Cardiology, University Medical Center, Jackson, MS.

Figure 1

Figure 2

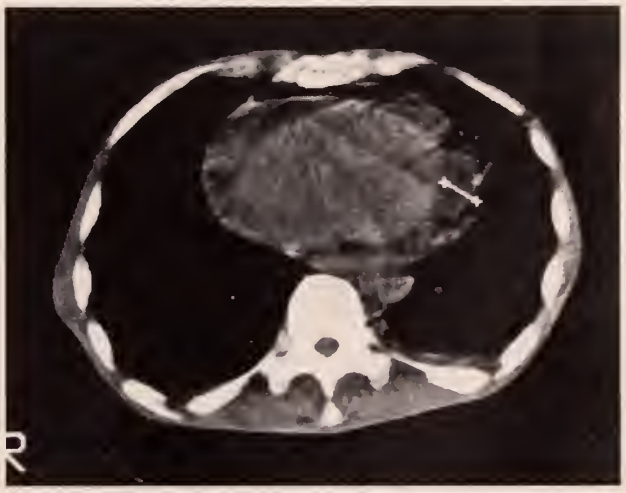

Figure 3

The pericardial drainage tube continued to drain 150 to 200 milliliters of fluid a day. On November 15, 1982 a barium swallow (see Figure 4) revealed an esophago-pericardial fistula. The patient's condition progressively deteriorated, and on the 25th hospital day he expired.

Discussion

The pneumopyopericardium in this case resulted from an esophago-pericardial fistula associated with extensive adenocarcinoma of the stomach. A pneumopyopericardium secondary to an esophago-pericardial fistula is almost invariably fatal. There are only five cases reported in which the patient survived.[3, 4] The most common cause of pneumopyopericardium, excluding trauma and foreign body perforation, is benign peptic ulceration of the esophagus or stomach.[5] Other common causes include carcinoma of the stomach or esophagus, pulmonary tuberculosis, adjacent pleural or lung infection, and rupture of an amebic or bacterial liver abscess into the pericardium.[6]

The patient with pneumopericardium or pyopneumopericardium may present with dramatic symptoms including severe precordial pain, dyspnea, syncope, chills, and possibly acute upper abdominal pain.[7] Occasionally there is a paucity of symptoms, and the diagnosis is made on a routine x-ray examination of the chest.[8] On physical examination there may be evidence of pericardial tamponade. Shifting precordial tympany can be detected. The heart sounds are usually distant and may

Figure 4

disappear when recumbent.[1] A loud, metallic, splashing sound of fluid flipped in a closed cavity containing air was originally described by Bricketeau in 1844. This auscultatory finding, termed "bruit de moulin," is said to be pathognomonic of a hydropneumopericardium.[9] A pericardial friction rub is sometimes present and is usually associated with other signs and symptoms of pericarditis.[8]

Roentgenography of the chest is probably the single most useful test in establishing the diagnosis of a pneumopyopericardium. If only a small amount of fluid is present, air may outline the entire heart. An air-fluid level is usually obvious and changes with body position. Occasionally the air-fluid level may only be apparent on an upright film.[6] A barium or meglumine diatrizoate swallow may be helpful in establishing the diagnosis. A technitium scan after swallowing labeled material has been employed to confirm the presence of a fistula. Oral methylene blue can demonstrate a fistula by appearing in the pericardial drainage.[3] The echocardiogram is helpful in establishing the presence of fluid. A broad band of echoes (air) recorded during held respiration which obscures the normal cardiac structures associated with dropout (gap) of the echoes posteriorly has been called the "air gap" sign. This sign is associated with pneumopericardium.[10] In this case, a CT of the chest was extremely helpful in establishing the diagnosis and in evaluating the primary disease process.

Prompt surgical drainage is necessary and is usually accomplished through a subxyphoid approach. The definitive surgical correction depends on the etiology and location of the fistulous tract. Before healing can take place the fistulous tract must be excluded.[3] ★★★

Dr. Russell: 2500 North State Street (39216)

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Short-Term and Long-Term Effects Of a High Blood Pressure Intervention Program

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DAVID A. WALSH, PH.D.†

RECENT DATA INDICATE that during the past twenty years a marked improvement has been documented nationally in the proportion of hypertensives achieving a controlled pressure.[1] In spite of this, only 34.1% of hypertensives on medication have realized a controlled pressure.[1] In an effort to improve the rate of high blood pressure control, numerous clinical trials and demonstration projects have been conducted during the past ten years. The Hypertension Detection and Follow-Up Program, for example, did demonstrate the health benefits of treating high blood pressure within a focused treatment program.[2] These benefits were measured both in terms of lower mortality rates and in a higher proportion of individuals achieving a controlled blood pressure as compared to individuals treated in existing community medical care facilities. Although this clinical/educational trial did demonstrate health effectiveness, other high blood pressure control demonstration programs have not found such positive outcomes.[3, 4] Consequently, even though the development of effective high blood pressure control strategies remains a health priority, the effectiveness of these control efforts is not definitively resolved.[5]

This study focuses on a seven-year follow-up of individuals enrolled in a high blood pressure management clinic operated in 1972-73 in central Mississippi. In addition to tracking their current mortality and therapeutic status, comparison is made to a group of individuals also diagnosed in 1972-73 as having hypertension but treated in community medical care facilities and not in the hypertension clinic.

In 1972-73 a study was conducted in a rural county of central Mississippi focusing on the random screening of about one-third of the black population for high blood pressure. In addition, a hypertension clinic was established to manage a portion of those individuals diagnosed as hypertensive.[6, 7] The treatment program in this clinic employed both clinical management and intensive health education which involved risk factor reduction and drug compliance information. Over a 17-month period 4,272 blacks five years of age and older were screened for high blood pressure. The average of two blood pressure measurements taken on the left arm from a sitting position using a mercury sphygmomanometer with the first and fifth phase Korotkoff sounds representing the systolic and diastolic pressures, respectively, were recorded for each individual. Of this group 1,101 were found to have an elevated blood pressure (≥160mm systolic and/or ≥95mm diastolic). Also, an additional 340 individuals were found to be on antihypertensive medication with a controlled pressure. Of the 1,101 individuals with an elevated pressure, 561 were clinically evaluated in that specifically designed hypertension clinic. Due to understaffing at the clinic the remaining 540 persons with an elevated pressure were referred to their own physicians. Of the 561 individuals evaluated at the clinic, 403 (about 72%) were diagnosed as having essential hypertension. Due mainly to the clients' desires to see their own physicians, 101 (25%) of the 403 confirmed hypertensives were referred to the existing community medical care system; almost 90% of both groups identified a regular source of medical care. Consequently, even though there was no random allocation into the two treatment groups, two distinct treatment settings were utilized by these 403 persons. Although the two clinical settings were distinctive, the two populations were characteristically similar. Approximately one-third of both the clinic-managed population and the community care population were male, 37% and 33%, respectively.

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At the time of diagnosis the community care panel was only slightly and insignificantly older than the clinic-managed population, 66.4 years and 64.1 years, respectively. The mean blood pressures of the two groups were also similar, 172.8mm/108.8mm for the clinic-managed population and 174.9mm/105.5mm for the community care population.

Even though the 17-month blood pressure screening and control effort was not designed as a longitudinal study, a rescreening was conducted in 1980 in order to provide insight into the long-term effects of a high blood pressure control program designed as a separate entity from the existing community medical care system. Trained interviewers were used to locate the 403 past participants. If the client could not be located, an effort was made through a relative or another person familiar with the individual to determine whether the client had migrated or was deceased and, if deceased, cause of death. Similar blood pressure measurement devices and techniques were employed in both the 1972-73 and 1980 studies. Also, similar numeric criteria were used to designate a hypertensive (≥160mm systolic and/or ≥95mm diastolic).

TABLE 1

AGE AND SEX SPECIFIC DEATH RATES, 1973-1980

	Hypertension Clinic-Managed		*Community Care-Managed*	
	Number	*Percent*	*Number*	*Percent*
Males				
Less than 60 years	6/28	21	1/3	33
60-69	8/34	24	8/11	73
Greater than 70 years	19/30	63	9/12	75
Females				
Less than 50 years	1/31	3	2/11	18
50-59	6/40	15	1/12	8
60-69	12/37	32	8/20	40
Greater than 70 years	15/37	41	9/14	64

TABLE 2

DEMOGRAPHIC DATA, 1980

	Hypertension Clinic-Managed		*Community Care-Managed*	
Age[1]	*Mean*	*Standard Deviation*	*Mean*	*Standard Deviation*
	65.6 (n=170)	14.2	65.6 (n=45)	12.0
Sex[2]	*Number*	*Percent*	*Number*	*Percent*
Male	59	34.5	8	17.8
Female	112	65.5	37	82.2
	(n=171)		(n=45)	

1. t-test: Not Significant.
2. Chi Square: $p<0.05$ for 1 degree of freedom.

Of the 403 individuals confirmed as hypertensive in the 1972-73 effort, 216 (or about 54%) were rescreened in 1980; 171 of them were treated by the hypertension clinic in 1972-73 and 45 by the community medical care system. In addition, 106 (26%) of the original 403 individuals were determined to be deceased; 62 (about 15%) had migrated out of the local area; and 19 (about 5%) could not be located or refused to participate. The mortality rate did vary significantly by treatment setting. Only 68 (23%) of the original 302 clinic-managed population died during the seven years since 1973 while 38 of the original 101 community care clients (almost 38%) had died in that time period. Age-and-sex-specific death rates were calculated for both treatment populations; the community care population had a higher mortality in six of the seven age-sex cohorts listed in Table 1. Combining these 2x2 mortality tables the community care population had a significantly ($P = 0.005$) higher mortality overall after adjusting for age and sex differences between the two populations.[8] The average time of death since program termination did not vary by population, 3.5 years for the clinic population and 3.2 years for the community care population. Also, no differences were found in cause of death between the two populations. The only characteristic found to be significantly different ($P<0.05$) between the two deceased populations was that individuals treated in the clinic had higher systolic pressures (182.8mm) at the time of diagnosis, as compared to the community care population (173.0mm).

Information on the 62 migrants showed that they were significantly younger than either the deceased populations or the populations rescreened in 1980. The 1972-73 blood pressures of the two migrant populations did not significantly differ.

Data on those 216 individuals rescreened in 1980 are illustrated in Tables 2-5. Demographic data shown in Table 2 indicate that there is no difference in the mean ages in 1980 between the two treatment populations; both groups had an average age of 65.6 years. The distribution of the two populations did vary by sex with the community care group having a significantly higher proportion of females, 82.2% as compared to 65% for the clinic-managed population.

Information on hypertension diagnosis and treatment is illustrated in Table 3. As reported, almost all (98%) of the community care population indicated

TABLE 3
DIAGNOSTIC STATUS, 1980

	Hypertension Clinic-Managed		*Community Care-Managed*	
	Number	*Percent*	*Number*	*Percent*
HBP has been diagnosed by MD[1]				
Yes	151	88.8	44	97.8
No	19	11.2	1	2.2
	(n=170)		(n=45)	
When HBP was diagnosed[1]				
0-5 Years ago	41	27.9	14	33.3
6-10 Years Ago	33	22.4	9	21.4
10+ Years Ago	73	49.7	19	45.2
	(n=147)		(n=42)	
Recalls being diagnosed and/or treated by hypertension clinic[1]				
Yes	128	75.3	30	66.7
No	42	24.7	15	33.3
	(n=170)		(n=45)	
Currently taking prescribed antihypertensives[1]				
Yes	106	70.7	35	79.5
No	44	29.3	9	20.5
	(n=150)		(n=44)	
Last visit to MD for HPB[2]				
0-6 Months Ago	127	86.4	35	83.3
7-12 Months Ago	4	2.7	2	4.8
1+ Years Ago	16	10.9	5	11.9
	(n=147)		(n=42)	

1. Chi Square: Not Significant.
2. Chi Square: Not Significant after collapsing "7-12 Months Ago" with "1+ Years Ago."

that they had been diagnosed by a physician as having high blood pressure. However, only 89% of the clinic-managed group reported a similar diagnosis. Almost one-third of both populations stated that their hypertension was diagnosed within the past five years. This corresponds with the proportion of clients who indicated that they do not recall being diagnosed and/or treated for high blood pressure by the clinic in 1972-73. A somewhat larger percentage of community care clients than clinic clients are currently taking a prescribed antihypertensive medication, 79.5% and 70.0%, respectively. Yet, there is almost no difference between the two groups in reporting when their last visit to a physician for high blood pressure management occurred.

Data on blood pressure levels for the 216 confirmed hypertensives rescreened in 1980 are illustrated in Table 4. There was a significant lowering of pressures for both treatment populations between time of diagnosis and 1980. Although pressures were significantly lower for both populations between 1972-73 and 1980, the pressures between the two populations did not significantly vary at either measurement. In other words, at entry into the study in 1972 the blood pressures of the two treatment populations were similar, 173.6mm/108.8mm for the clinic-managed population and 177.2mm/109.2mm for the community care group. In 1980 the blood pressures of the treatment populations were also similar. The mean pressures of the clinic-managed population in 1980 were 163.0mm/97.0mm while those of the community care population were 163.0mm/96.0mm.

Table 5 illustrates the 1980 therapeutic status of the two treatment populations. As shown, about 36% of those clients managed in the hypertension

TABLE 4
MEAN BLOOD PRESSURES, 1972 AND 1980

	*1972**		*1980**	
Hypertension Clinic Managed	*Mean*	*Standard Deviation*	*Mean*	*Standard Deviation*
Systolic[1]	173.6	26.2	163.0	28.4
Diastolic[1]	108.8	16.1	97.0	17.8
	(n=171)		(n=171)	
Community care managed				
Systolic[2]	177.2	26.8	163.0	36.8
Diastolic[2]	109.2	17.3	96.0	18.5
	(n=45)		(n=45)	

* t-test not significant between groups with the same years for both systolic and diastolic pressures.
1. t-test: $t<0.001$.
2. t-test: $t<0.01$.

TABLE 5
THERAPEUTIC STATUS, 1980[1]

	Hypertension Clinic-Managed		Community Care-Managed	
	Number	*Percent*	*Number*	*Percent*
Controlled	62	36.3	18	40.0
Uncontrolled	109	63.7	27	60.0
	(n=171)		(n=45)	

1. Chi Square: Not Significant.

clinic had a controlled blood pressure, while 40% of those managed in the community had controlled pressures in 1980; the differences between the groups are not statistically significant.

In summary, in 1972-73, 302 confirmed hypertensives agreed to be managed in a focused high blood pressure treatment and education program while an additional 101 hypertensives confirmed during the same screening effort elected to remain with their regular source of community medical care; although characteristically similar, random allocation into the two treatment settings was not employed. Seven years after the termination of the high blood pressure intervention program, an attempt was made to rescreen both treatment populations; 171 clinic-managed clients and 45 community care clients were rescreened. Information obtained during the rescreening documented that about one out of five of the original 302 clinic clients had died since the program terminated in 1973, while almost two out of five of the original 101 community care clients had died during the past seven years. After adjusting for age and sex differences between the two treatment populations this difference in mortality was statistically significant ($P = 0.005$). The only factor found to be associated with this differential mortality rate was that the deceased managed in the clinic had a significantly higher ($P = 0.05$ systolic pressure at diagnosis, 182.8mm, than the deceased managed in the community. Possible explanations for the mortality differences center mainly on the health benefits derived from such a focused high blood pressure control program or possibly from random variation.

The therapeutic status of the two treatment populations can be viewed from both short-term and long-term perspectives. At the termination of the intervention program in 1973, 56% of those participating in the intervention effort had achieved a controlled blood pressure.[7] This rate of control is significantly higher than that achieved in the community at that time. Adjusting for the rate of confirmation, the initial random survey found 30% of the hypertensives in the community on medication with a controlled pressure. The 1980 survey determined that the therapeutic status of the two treatment populations was no longer significantly different; 36% of the clinic population and 40% of the community care population had a controlled pressure in 1980. Consequently, the data appear to indicate that while such programs are in operation, or at time of termination, health benefits measured as the proportion of individuals realizing a controlled blood pressure can be achieved. However, these health benefits diminish over time. In this study, seven years after the intervention program terminated the survivors of the two treatment populations had similar rates of blood pressure control. These data also indicate a mortality benefit for those participating in the clinic as compared to those receiving treatment in the community. However, no supportive data are available to definitively explain that outcome.

This study was not designed as a true clinical trial. This fact, obviously, introduces some cautions when examining the treatment outcomes. The data do indicate, however, a short-term health benefit as measured by therapeutic status. This benefit was not detectable seven years after the intervention activity terminated. And, although not explainable, a significant mortality benefit over a seven-year period was also observed for those participating in the hypertension clinic as compared to those treated in community medical care facilities. ★★★

Dr. Frate: P.O. Box 283 (39079)

Acknowledgement

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SPECIAL ARTICLE

Radiological Seminar CCXLI: Right Upper Quadrant-Epigastric Pain — Role of Radiographic Tests To Diagnose Cholecystitis

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Jackson, Mississippi

FEVER, LEUKOCYTOSIS and right upper quadrant-epigastric pain are common presenting symptoms for several abdominal organ conditions. Acute cholecystitis is one which requires prompt surgical attention, while surgery could be detrimental in some others with similar clinical presentation. The role of Tc-99m biliary scintigraphy and other radiological and ultrasound examinations in diagnosing cholecystitis is discussed in this article.

Acute cholecystitis is characterized by gallbladder wall edema and congestion with cystic duct obstruction. Although cholelithiasis is a common finding in acute cholecystitis, it is not a hallmark for acute cholecystitis. If cystic duct obstruction persists, it may lead to hemorrhagic necrosis of the gall bladder wall. Further evolution may result in gangrenous changes leading to perforation of the gallbladder, resulting in peritonitis. Therefore, a noninvasive study demonstrating findings of cystic duct obstruction would be ideal for presurgical evaluation of patients with abdominal pain and suspected acute cholecystitis.

Scintigraphy, utilizing Tc-99m hepatobiliary agent, offers very high sensitivity and specificity in detection of acute cholecystitis. Some authors have reported sensitivity and specificity of about 95% and 90% respectively. Any one of the Tc-99m hepatobiliary agents are adequate for most clinical situations. Tc-99m di-isopropyl iminodiacetic acid (DISIDA) is a commonly used agent. Successful results can be obtained in patients with moderate hyperbilirubinemia with Tc-99m DISIDA. Cholescintigraphy is a noninvasive study requiring only intravenous injection of the agent. It requires no special patient preparation and usually provides results within one to four hours.

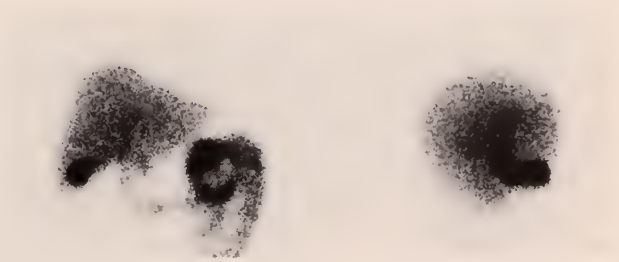

Figure 1. Anterior and right lateral view showing the activity in the gallbladder, the common bile duct, and the small bowel at 30 minutes.

Interpretation of Scintiscan

Normal

Prompt visualization of liver begins following intravenous administration of Tc-99m DISIDA. Visualization of gallbladder and common bile duct occurs within 30 to 45 minutes, and visualization of intestinal activity occurs before one hour (see Figure 1). Since the normal excretion of bile includes passage into the gallbladder before excretion in the

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From the Department of Radiology, University Medical Center, Jackson, Mississippi.

small intestine, such findings would indicate a nonobstructed cystic duct. Therefore, absence of acute cholecystitis is inferred.

Abnormal

Nonvisualization of the gallbladder occurs despite prompt visualization of the liver with subsequent visualization of the common bile duct and activity in the small intestine (see Figure 2). Since normally, excretion of bile includes passage into the gallbladder before its excretion in the common bile duct and intestine, an obstruction of the cystic duct would not allow the passage of the radiotrace into the gallbladder. However, the obstruction of the cystic duct would not impede its passage in the common bile duct and intestine. Cystic duct obstruction occurs in acute cholecystitis due to edema and congestion with or without presence of a cystic duct stone.

Indeterminate (obstructive pattern)

Nonvisualization of the gallbladder, the common bile duct and the intestinal activity within one hour, despite prompt uptake of the radiotracer by the liver is typically seen in common bile duct obstruction (see Figure 3). Associated cholestasis is thought to be responsible for nonvisualization of the proximal bile duct and the gallbladder. In obstructive pattern the nonvisualization of the gallbladder cannot be inferred as cystic duct obstruction, therefore the above described scintiscan findings are indeterminate for the detection of acute cholecystitis.

Preferred Gallbladder Filling

In this pattern, in addition to prompt visualization of liver activity, preferential gallbladder filling and common bile duct with the absence of intestinal activity within 60 minutes is noted (see Figure 4). This pattern is thought to result from functional distal common bile duct obstruction due to ampullitis or enhanced tone of Sphincter of Oddi not allowing passage of radiotracer in the intestine. The prompt uptake of the radiotracer by the liver allows excretion of the radiotracer in the gallbladder and common bile duct without passage of activity in the intestine. In such patients four-to-six hour delayed images will also show preferential gallbladder filling with decreasing activity from the liver.

Delayed Gallbladder Visualization

The gallbladder is visualized between one to four hours after injection in spite of the prompt visualization of the liver and timely visualization of common bile duct and intestine (see Figure 5). It is commonly seen with chronic cholecystitis. Approximately 5% of patients with acute cholecystitis show delayed gallbladder visualization indicating partial cystic duct obstruction, presumably from mucosal edema, cystic duct debris or bile stasis.

Figure 2. Anterior and right lateral view at 60 minutes showing no activity in the gallbladder despite the presence of activity in the common bile duct and the small bowel.

Figure 3. Anterior views at 15 minutes and 60 minutes showing prominent activity in the liver but no visualization of the gallbladder, the common bile duct, and the small bowel.

Figure 4. Anterior and right lateral views at four hours showing no activity in the small bowel in spite of visualization of the gallbladder and the common bile duct.

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MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously

USAGE IN PREGNANCY AND LACTATION: **An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.**

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic® (meprobamate with aspirin) is not recommended for patients 12 years of age and under

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MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity

GI: Nausea, vomiting, diarrhea

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate-mebutamate and meprobamate-carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura

OTHER: Exacerbation of porphyric symptoms

DOSAGE AND ADMINISTRATION:
Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under

OVERDOSAGE:
Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range of meprobamate after therapeutic doses. The level may occasionally be as high as 3.0 mg percent

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur

At levels greater than 20 mg percent, more fatalities than survivals can be expected

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption

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Figure 5(a) Anterior views at 30 minutes and 60 minutes showing activity in the common bile duct and the small bowel; (b) Right lateral and anterior view at four hours on the same patient showing delayed visualization of the gallbladder with more activity in the small bowel.

Other Modalities

Oral Cholecystography

Oral cholecystography is not an ideal method for evaluation of patients with suspected acute cholecystitis for the following reasons. In addition to not being a sensitive study, it frequently takes 48 hours to provide the results. It fails to show the gallbladder when the total serum bilirubin level is above 2mg/dl. Poor absorption, vomiting, and gastric obstruction interferes with absorption of the iodinated contrast, thus resulting in nonvisualization of the gallbladder despite absence of gallbladder pathology.

Intravenous Cholangiography

Intravenous cholangiography has been utilized in the past, but it has much less sensitivity compared to hepatobiliary scintigraphy. Hyperbilirubinemia degrades the visualization of the gallbladder, thus making it less than an ideal modality in evaluation of all the patients which suspected acute cholecystitis. Infusion tomography of the gallbladder is a highly sensitive study for the detection of acute cholecystitis; however, the specificity of this test is unacceptable due to false positive study in chronic cholecystitis.

Ultrasound

Ultrasound imaging is very sensitive for detection of cholelithiasis, but all the patients with cholelithiasis do not have acute cholecystitis. Presence of cystic duct calculus and/or gallbladder wall edema may indicate presence of acute cholecystitis, but these findings are not seen on ultrasound in all the patients with acute cholecystitis. In patients with acalculus, acute cholecystitis ultrasound study is not ideal. Overall the sensitivity and specificity for detection of acute cholecystitis by ultrasound is reported to be about 85% and 55%. Low specificity of ultrasound in detection of acute cholecystitis makes it less than ideal as only study for detection of acute cholecystitis in all the patients.

Summary

Cholescintigraphy utilizing Tc-99m DISIDA is highly efficacious noninvasive modality with very high sensitivity and specificity. Oral cholecystography is not a procedure of choice in the detection of acute cholecystitis because of the possible interference in absorption of the contrast agent by various gastrointestinal pathology resulting in nonvisualization of the gallbladder without acute cholecystitis, prolonged time required before obtaining results in some patients, and nonvisualization of the gallbladder in patients with hyperbilirubinemia. Intravenous cholangiogram is not the preferred modality because of possible unreliable results with increasing hyperbilirubinemia. Ultrasound study as the only study may miss all the patients with acalculus cholecystitis. Gallbladder sonography with biliary scintigraphy would diagnose most of the cases of acute cholecystitis. ★★★

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The President Speaking

Letter from a Friend

Ellis M. Moffitt, M.D.
Jackson, Mississippi

A friend who is retired from General Motors left this memo on my desk the other day. It is dated March 1984, and is entitled *Report to Retirees*.

"Last year, U. S. businesses paid about $80 billion in health insurance premiums for their employees, retirees, and dependents. General Motors alone paid nearly $2.2 billion for health care coverage in 1983, more than half its total earnings — or about $475 per vehicle produced. From past experience GM expects this bill to double in about five years unless something is done soon to control the escalating costs. . . .

"While a solution to the total problem will require the cooperation of everyone from doctors, hospitals and insurance carriers to companies, unions, employees and retirees, there are several things that can be done to help contain these rising costs. For example, GM is working closely with its health care carriers and the various unions to try to develop innovative approaches to controlling costs, while continuing to provide top quality medical care."

The memo goes on to explain other steps being taken in the future to contain costs. The first of these to go into effect for all GM employees is a mail order prescription service for employees. Other steps down the road will probably involve the physician or hospital directly.

I am not sure how many employees or plants GM has in Mississippi, but I do know there are Packard Electric plants in Clinton, Brookhaven, and Philadelphia and a Delco Remy plant in Meridian. My point is this: we do have this industrial giant involved in the economy of our state, and we are grateful to have this involvement. Let's do everything within our control to keep health care costs within reason.

One of the best allies we have in medicine is the business community. If we lose this friend we are in trouble. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXV, Number 10

OCTOBER 1984

Have You Looked Back To See What's Gaining On You?

During a discussion of his philosophies on living, baseball immortal Satchel Paige is credited with saying, "Don't look back because something might be gaining on you." This philosophy may have served Paige well, but it has not served medicine well, and will not do so in the future.

For many years physicians were too busy, preoccupied, and complacent to look back and see what was gaining on them. This approach is no longer acceptable for medicine as a whole or for individual physicians.

We have been caught by a multitude of problems which must be addressed, not simply beause we are against someone else trying to influence our lives. It must be done in order to survive.

Government subsidies and interventions, changing attitudes of other third party payors, influence of labor and management, physician surplus, fee freezes, "participating vs. non-participating," foreign medical graduates, HMO's, PPO's, and the Gatekeeper concept are here and have to be addressed directly.

In dealing with any of these it is important to understand what they are and how they impact on your practice. I have been impressed by the number of physicians who know little about the new "participating vs. non-participating" regulations applicable to Medicare and who are waiting to be told by someone else what they should do.

Whether you agree or disagree with these concepts will not protect your practice. Ignoring them or allowing others to make decisions for you is inviting disaster.

To understand what is going on in any of these areas will require an effort on your part, and probably the most important step is suppressing your objections so that you will be able to evaluate the situation fully, allowing you to make an informed decision.

Don't follow the advice of Paige. Look around you and you will find a multitude of changes, all nibbling away at you. Your best protection from this group of "Pac-Man" like creatures is a dedicated involvement in the affairs affecting you.

MYRON W. LOCKEY, M.D.
Editor

COMMENT

How to Multiply Grocery Store Prices

By Paul Harvey

(Editor's Note: The following commentary is reprinted with permission from Paul Harvey News.)

There is a way to make grocery store prices much higher than they are.

As is, food is one of the consumer's best bargains. The cost-of-living would be much higher than it is except for comparatively reasonable food prices.

But there is a way to skyrocket those grocery store prices if you want to.

If you want to multiply the prices of everything you buy at the grocery store, here's how —

Subject your grocer to the same regulations under which hospitals are required to operate. That means:

The grocer would have to keep a record of the total number of customers served, broken down by employer.

He would have to record the precise number of minutes each customer was in the store.

The record must show which customers purchased only meat and nothing else, which customers purchased only bread and nothing else, which customers bought both bread and meat.

Separately the grocer's report must state which customers bought meat and milk. Also the number of customers who came in for one item and purchased more than one.

Further, the grocery store is required to give away

fifty thousand dollars worth of groceries each year and signs must be posted in the store in three languages telling customers that the store is required to do this. Records must be maintained on all customers and all groceries given away under this plan.

Further, for one half of the customers the store is not allowed to set prices. Government will determine those prices — and if those prices are arbitrarily held down to "no more than last year's prices" then the store owner must pay his higher expenses by charging higher prices to the other half of his customers.

But for that half, the store cannot collect cash from the customer, but must send a bill to the customer's employer.

Further, the store manager is responsible for planning each customer's meals. If he errs in judging what's best, the customer may sue him.

Also — the store must keep careful records of each can of peas sold — by brand name, size, customer age and employer of customer.

Similar reports are required on each product sold.

The store must certify in writing that each customer needs groceries before permitting him to enter the store.

The store must have a committee to establish a "shopping time limit" for each customer. Any customer permitted to shop longer than the pre-established time may not be required to pay for his or her groceries.

The store must have the written approval of government authorities before adding or deleting any product or brand.

The store manager must have a Master's Degree in Marketing.

There are many more regulations to which hospitals are subject, but this is enough to help you to understand why the costs of medical care have gone up faster and higher than the price of groceries.

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Federal Deposit Insurance Corporation

Medico-legal brief

Physicians Negligent in Discharging Mental Patient Who Murdered Family

Three physicians were negligent in discharging state mental hosptial patient who later killed his mother and brother, a federal appellate court for Kansas ruled.

The 19-year-old patient was found mentally ill by a probate judge on January 7, 1974, and ordered to enter a state hospital. He had threatened to kill his grandparents with a hatchet and meat fork. On April 19, 1974, a team of physicians at the hospital decided that the patient was not dangerous to himself or others and discharged him. A week later he murdered his mother and brother.

His father filed a wrongful death action on behalf of himself and his other two sons against the physicians who participated in the discharge decision. A psychologist settled the claim against him before trial. A jury found in favor of the father for $92,300.

On appeal, the federal appellate court certified two questions of Kansas law to the Kansas Supreme Court. The Supreme Court ruled that a claim arising out of a negligent release of a patient who has violent propensities is a valid cause of action. The court also said that staff physicians of a state mental institution are not immune from civil liability for release of a dangerous patient.

Deciding a few remaining issues, the appellate court said that the trial court did not abuse its discretion in allowing a psychologist to testify on the standard of care of the physician-defendants. The court said that the decision in question involved psychological rather than medical inquiry and the

(Continued on page 284)

Board of Trustees Holds Summer Meeting

MSMA's Board of Trustees held its regular summer meeting on August 16-17. Primary business coming before the Board for action were referrals from the recent meeting of the MSMA House of Delegates and planning for the 1984-85 association year.

The Board activated two new MSMA Committees. One, a Committee on the Environment of Medicine, will study and recommend long range plans for the association to serve its membership in the new environment of medicine predicted for the rest of this century. The committee will also serve as a clearinghouse for information to the membership on changes occurring in health care reimbursement mechanisms. A Council on Public Relations as approved by the House of Delegates was also named and will begin its new program this fall.

The Board acted to implement a building program as authorized by the House of Delegates. Details of the program will be publicized to the membership beginning this fall. Plans call for construction of the building to begin next March.

Based on other referrals from the House of Delegates the board implemented plans for a new Hospital-Medical Staff Section at the 1985 Annual Session. MSMA's anti-nuclear waste disposal campaign was also reviewed, and a 1985 legislative program was approved for distribution to the membership.

In other activities, the Board discussed implementation of Project MEDVOTE by the MSMA Auxiliary. The project is directed at registering and encouraging physicians, their families and employees to vote in this fall's election.

Results of a membership opinion survey of activities of the Mississippi Department of Health were studied, and the Board directed that pertinent conclusions from the survey be brought to the attention of the Department.

MSMA officers and Board members attending the August meeting included: W. Joseph Burnett, M.D., Oxford, chairman; William C. Gates, M.D., Columbus, vice chairman; Roy D. Duncan, M.D., Pascagoula, secretary; Virginia S. Tolbert, Ruleville; William B. Hunt, M.D., Grenada; C. G. Sutherland, Jackson; Martin H. McMullan, M.D., Jackson; George L. Arrington, M.D., Meridian; David M. Owen, M.D., Hattiesburg; David R. Steckler, M.D., Natchez; Ellis M. Moffitt, M.D., Jackson, president; Ralph L. Brock, M.D., McComb, president-elect; Whitman B. Johnson, Jr., M.D., Clarksdale, immediate past president; J. Elmer Nix, M.D., Jackson, secretary-treasurer; Carl G. Evers, M.D., Jackson, speaker of the House; James C. Waites, M.D., Laurel, vice spreaker of the House; J. Ed Hill, M.D., Hollandale, delegate to AMA; W. Lamar Weems, M.D., Jackson, delegate to AMA; and Sidney O. Graves, Jr., M.D., Natchez, delegate to AMA.

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Forrest General Hospital to Host Seminar in Office Cardiology

A seminar in office cardiology will be held November 8 at Forrest General Hospital in Hattiesburg.

Topics include "Common Arrhythmias and Their Treatment Including Pacemaker Indications," "Newer Concepts for Treatment of Congestive Heart Failure," "Risk Factor Management," "Current Medical Therapy of Angina Pectoris," "Mitral Valve Prolapse," and "Non-Cardiac Causes of Chest Pain."

The seminar is accredited by the AMA and the American Academy of Family Physicians. There is no registration fee.

For information, contact Ben M. Carmichael, M.D., 415 South 28th Avenue, Hattiesburg, MS 39401.

POSTGRADUATE CALENDAR

Oct. 26-28
ACLS Provider Course
University Medical Center, Jackson

Nov. 2
Communicative Disorders Symposium and Godfrey Arnold Lecture
University Medical Center, Jackson

Nov. 17
Stroke, Dementia and Other CNS Disorders
University Medical Center, Jackson

Nov. 9-10
An Approach to Differential Diagnosis in Musculoskeletal Pain
Holiday Inn North, Jackson

For registration information and a brochure, contact Continuing Education at the University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505, or call (601) 987-4914.

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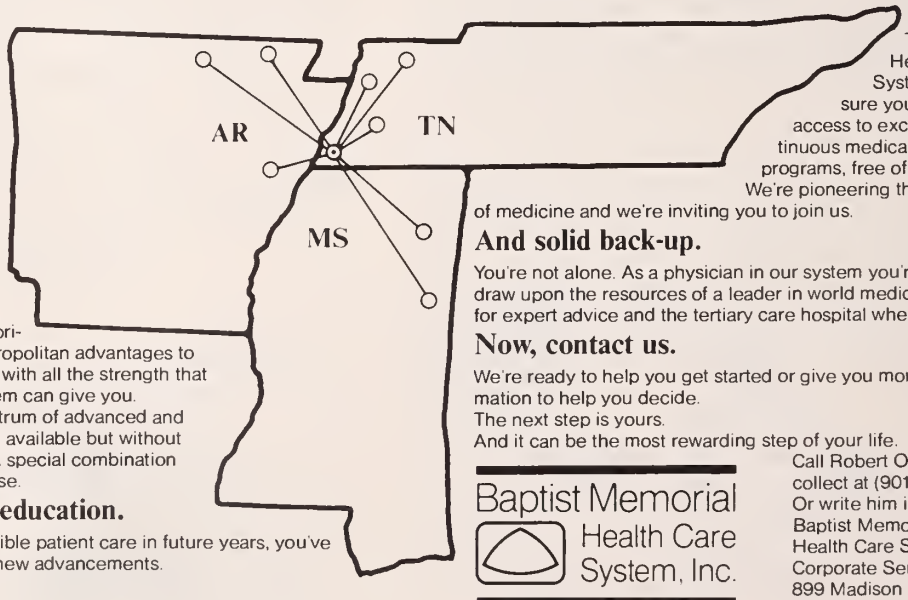

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PERSONALS

James Achord of UMC was on the faculty for a recent workshop at the American Association for Clinical Chemistry, Inc., in Washington, DC.

Claudia Beghe of UMC attended the national American Diabetes Association meeting in Las Vegas. Dr. Beghe recently was elected president of the Greater Jackson Affiliate of the ADA.

Milam Cotten of Hattiesburg has been elected president of the Hattiesburg-Laurel Ophthalmological Society. Eric Lindstrom of Laurel was named secretary-treasurer.

William F. Craven announces the opening of his office for the practice of family medicine at 2165 South Lamar Boulevard in Oxford.

Robert L. Crocker of Brandon announces the association of Walter M. Burnett for the practice of family medicine at the Reservoir Family Clinic, 101 Spillway Road.

Edgar Draper of UMC was consultant to the VA Medical Center in Biloxi in July.

Chris P. Etheridge has resumed practice at Mississippi Orthopedic Specialists in Jackson for hand/upper extremity surgery, replantation surgery and orthopedic microsurgery.

T. A. Graves announces the opening of his office for the practice of otolaryngology at 4500 15th Street in Gulfport.

James Hardy of UMC presented a round of lectures in Bogota, Colombia, in August.

Armin Haerer of UMC was in Vancouver, British Columbia, to speak at the International Epidemiological Association's annual scientific meeting recently.

Jack Graham Hudson has associated with the Family Clinic, 502 Broad Street in Columbia, for the practice of family medicine.

Robert B. Ireland, Jr. of Jackson has been appointed medical director of Jackson After Hours Clinic, 5606 Old Canton Road.

Robert Jordan has associated with Family Medical Associates, 5002 Highway 39 North in Meridian, for the practice of family medicine.

Robert L. Lewis has associated with the Catchings Clinic, 451 Bank Street in Woodville, for the practice of internal medicine.

Robert R. Lowe, Jr. of Jackson received a Distinguished Service Award presented by the American Heart Association in Mississippi.

J. Marc Majure has associated with Children's Medical Group, 800 Carlisle Street in Jackson, for the practice of pediatrics.

James M. Mitchell has associated with Primary Care Associates, 206 Jeff Davis Avenue in Long Beach, for the practice of family and industrial medicine.

Francis Morrison of the UMC attended a meeting of the Board of Directors of the South Central Association of Blood Banks in Austin, Texas, and a meeting of the International Society of Experimental Hematology in Atlanta, Georgia.

William Nicholas of UMC attended the national American Diabetes Association meeting in Las Vegas as council member representing the Mississippi Affiliate. He is serving his second term as state president of the ADA.

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Ralph D. Peeler, III announces the opening of his office for family practice at Norfleet Medical Building in Senatobia.

Sybil F. Raju has associated with Central Dialysis Unit, Inc. and Lakeland Medical Clinic, for the practice of internal medicine and nephrology at 381 Medical Drive in Jackson.

Kenneth J. Reid, Jr. of Meridian was elected to fellowship in the American Academy of Pediatrics.

Jerry W. Sheffield announces the opening of his office for the practice of family medicine at 918 South Gloster in Tupelo.

Gordon W. Sluis of Vicksburg has been named a diplomate of the American Board of Pediatrics.

Hans-Karl Stauss and Walter Thomas Rueff of Jackson announce the association of Fred Wallace Rushton, Jr. for the practice of general and vascular surgery.

Raj Subnani announces his association with the Aberdeen Medical Clinic, 501 South Chestnut Street, for the practice of general, vascular and thoracic surgery.

The Newborn Group, 1850 Chadwick Drive in Jackson, announces the association of David McRae Temple for the practice of newborn medicine.

Joseph B. Witty, Jr. has associated with Hugh W. Stancill and William R. Greene of Laurel for the practice of obstetrics and gynecology.

Eugene Woods of Jackson was appointed by the Hinds County Supervisors to a post on the Hinds General Hospital board of trustees.

Bennie B. Wright, Jr. has associated with Cleveland Clinic, Highway 8 East in Cleveland, for the practice of general surgery.

JOIN MPAC TODAY

DEATHS

Hale, Carl R., Hattiesburg. Born Corinth, MS, March 2, 1929; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1954; interned King County Hospital, Seattle, WA, one year; radiology residency, Vanderbilt University Hospital, Nashville, three years; member of South Mississippi Medical Society, MSMA and AMA; died June 14, 1984, age 55.

Rouse, H. K., Jr., Gulfport. Born Poplarville, MS, June 24, 1903; M.D., Tulane University School of Medicine, New Orleans, 1931; interned Charity Hospital, New Orleans, one year; residency, EENT Hospital, New Orleans, 1935-37; Member of Coast Counties Medical Society and MSMA; died Aug. 11, 1984, age 81.

Controversies IN MEDICINE

- Physician Unions
- Inflammatory Cell and Free Radicals
- Colonoscopy: Screening for Colon Cancer
- Paramedics: Pros and Cons
- Organ Transplants: Impact on Medical Economy
- Parenteral Nutrition: Surgical and Research Aspects
- Alternatives in Breast Surgery
- National Medical Policies

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A WORD TO THE WHYS

WHY AMA? Commitment to maintaining high quality at all levels of medical education is one of the AMA's proudest traditions. The AMA creates policy for medical education, participates in accreditation activities, and supplies the public with information on medical education issues. Proven dedication to high standards in medical education: it's one more good reason why you should be a part of the AMA.

WHY AMA? Now, for the first time there's a forum for hospital medical staffs to meet nationally to discuss common problems and changes in physician-hospital relationships. The Hospital Medical Staff Section was recently created by the AMA to provide leadership in ensuring quality patient care during this period of massive hospital restructuring. It's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

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NEW MEMBERS

Franklin, Johnny Buck, McComb. Born Jackson, MS, May 11, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, Baylor Affiliated Hospitals, Houston, TX, 1980-83; elected by South Central Mississippi Medical Society.

Hays, Frank Buford, Jr., Columbus. Born Jackson, MS, Sept. 20, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, Baptist Memorial Hospital, Memphis, TN, 1980-83; elected by Prairie Medical Society.

Headley, David M., Port Gibson. Born Port Gibson, MS, Jan. 17, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family practice residency, Memorial Medical Center, Corpus Christi, TX, 1980-83; elected by West Mississippi Medical Society.

King, E. Gordon, Monticello. Born Duncan, OK, May 27, 1937; M.D., University of Oklahoma College of Medicine, Oklahoma City, 1962; interned and general surgery residency, Tripler General Hospital, Honolulu, Hawaii, 1962-67; elected by South Central Mississippi Medical Society.

McGee, Thomas Page, Jr., Grenada. Born Indianapolis, IN, Aug. 7, 1942; M.D., University of Tennessee Center for Health Sciences, Memphis, 1968; interned and pathology residency, Methodist Hospital, Memphis, 1968-75; elected by North Central Medical Society.

Mitchell, John Edward, Cary. Born Birmingham, AL, Aug. 31, 1954; M.D., University of South Alabama College of Medicine, Mobile, 1980; interned and family practice residency, Selma Medical Center, Selma, AL, 1980-83; elected by West Mississippi Medical Society.

Nayak, Mina C., Laurel. Born India, May 8, 1948; M.D., Medical College, Ahmedarad, India, 1970; interned Lafayette Charity Hospital, Lafayette, LA, one year; ob-gyn residency, Charity Hospital, New Orleans, 1976-79; elected by South Mississippi Medical Society.

Nicholson, Michael Thomas, Meridian. Born Oxford, MS, April 8, 1945; D.O., University of Health Sciences College of Osteopathic Medicine, Kansas City, 1976; interned Sun Coast Hospital, Largo, FL, one year; elected by East Mississippi Medical Society.

Parsons, Prentiss Morris, Ackerman. Born Kilmichael, MS, July 15, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and family practice residency, Spartanburg General Hospital, Spartanburg, SC, 1981-84; elected by North Central Medical Society.

Russell, Dave Austin, Meridian. Born Oxford, MS, April 9, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, medicine residency, and cardiology fellowship, University Medical Center, Jackson, MS, 1976-83; elected by East Mississippi Medical Society.

Sheffield, Paul E., Jackson. Born Jackson, MS, September 1, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family practice residency, University Medical Center, Jackson, 1980-83; elected by Central Medical Society.

Smith, George V., Grenada. Born Jackson, MS, June 15, 1932; M.D., Harvard Medical School, Boston, MA, 1957; interned Charity Hospital, New Orleans, one year; general surgery residency, Hartford Hospital, Hartford, CT, 1959-64; elected by North Central Medical Society.

Tartt, Stephen W., Meridian. Born New Orleans, Jan. 20, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and general surgery residency, University Medical Center, Jackson, 1978-83; peripheral vascular surgery fellowship, University of Tennessee, Memphis, 1983-84; elected by East Mississippi Medical Society.

Next Month In JOURNAL MSMA

Severe Neutropenia and Infectious Mononucleosis

Metastases to Bone as Primary Sign of Laryngeal Cancer

Percutaneous Renal Calculi

Case Report XX: Maternal Mortality Study

Medico-Legal Brief

(Continued from page 276)

expert was competent to testify. The court properly excluded testimony by the patient and a minister about the volatile and abusive family history. The court said the patient's theory of contributory negligence by the family in causing the deaths was invalid.

The trial court did not err in admitting a videotape of the patient made during his confession to the police on the day of the murders. The tape did not show the patient as a raving incompetent and was not unduly prejudicial, the court said. The decision in favor of the father was affirmed. — *Durflinger v. Artiles*, 727 F2d 888 (C.A.10, Kan., Jan. 27, 1984)

RECOLLECTIONS

Some comments by a former MSMA president, published ten years ago in JOURNAL MSMA, have relevance today's medical environment.

Dr. J. T. Davis, in his President's Page article of October 1974, observed, "In this day of increasing cynicism and waning credibility the crisis in professional liability has become a nightmare to the medical profession."

"To the public and to the politician the rash increase of malpractice litigations infers that the physician is delivering less than quality medical care, has grown more irresponsible in his 'dollar oriented' practice, and is less responsive to the needs of his patients. All this tends to widen the credibility gap and serve as a basis for further legislative controls. Clearly the time has come for the physician . . . to do something about this dilemma."

Suggesting steps for the physician to take, he continued, "Good rapport between doctor and patient is paramount. . . . Good public relations exercised by the office receptionist, nurse and finally by the doctor may serve as one's best defense. To communicate with a sense of kindness, warmth and understanding in addition to one's records reflecting concern and quality care may prove to be one's greatest asset in a court of law."

PHYSICIANS NEEDED

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact one of the following Medical Relations Officers: Henry Klar (Ext. 2276), Martina Mayfield (Ext. 2227), or Neil McGaughey (Ext. 2249).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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IN CONCLUSION

More medical students and residents than ever before are in the medical education system, but they are receiving less financial aid, according to the 84th Annual Report on Medical Education in the U.S., published in the Sept. 28 JAMA. Financial assistance from all sources declined by 6%; scholarship funds decreased 8%; and loan funds decreased 4%. Average education debt reported by senior students was nearly $24,000. More than 13% of 1983's graduating class reported debts of at least $30,000.

An article in the September Annals of Emergency Medicine suggests that training of up to 12 million Americans in CPR is commendable, but "limited resources might be more effectively directed at those people most likely to use such skills," such as family members of patients with known coronary heart disease. The comments were based on a study that found only 9% of family members of patients with coronary heart disease had taken a CPR course within the past three years, while 34% of comparison groups had.

Faster healing of burn wounds might be realized by applying a live yeast cell derivative ointment, according to a new study from the burn center of Alta Bates Hospital in Berkely, California. The September issue of Archives of Surgery reports on a double-blind, randomized, single-center inpatients study involving 26 human skin graft donor sites in 9 patients. Statistically significant earlier healing occurred in donor sites treated with the yeast cell ointment.

The presence of life-threatening bacteremia in newborn infants can be predicted with great accuracy by evaluating tracheal secretions stained by the Gram method, according to a study in the September issue of American Journal of Diseases of Children. The report stated, "The presence of bacteria had a 74% sensitivity and a 47% predictive accuracy in identifying neonates with bacteremia before 12 hours of age." The report also noted that specificity was 98%.

Subtle shifts in emphasis and in priority are placing medical teaching at the bottom of the triad of teaching, research and patient care in university medical centers, warns the president of Johns Hopkins University in the September 21 JAMA. Urging reinforcement of the role of teaching, he says, "...medicine is, or should be, a learned profession...the physician as healer needs some undefined dimension of social poise and human depth that goes beyond biomedical science."

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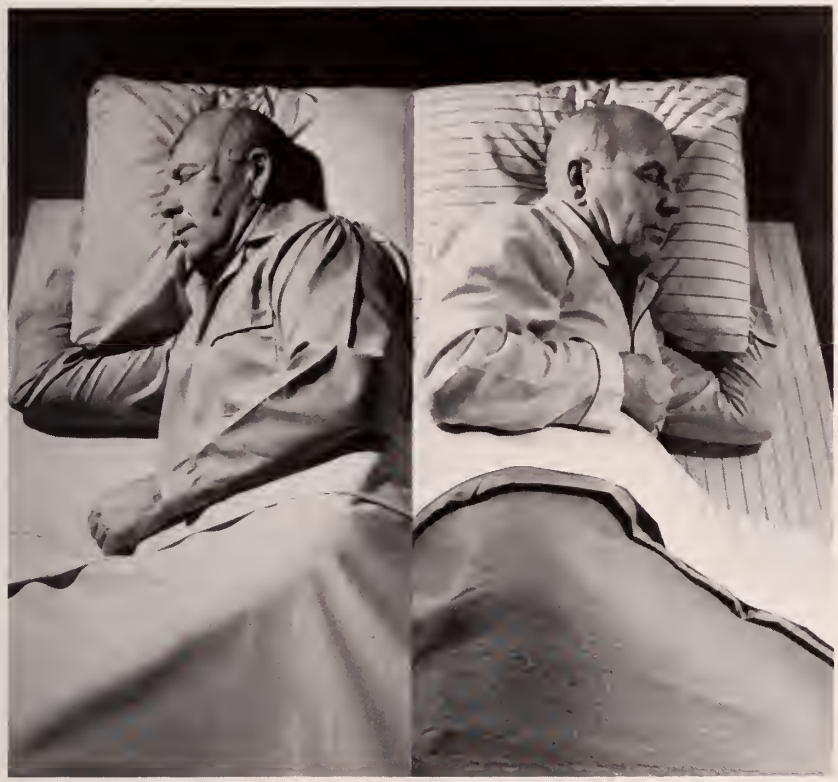

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References: **1.** Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM. *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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November 1984

JOURNAL of the MISSISSIPPI State Medical Association

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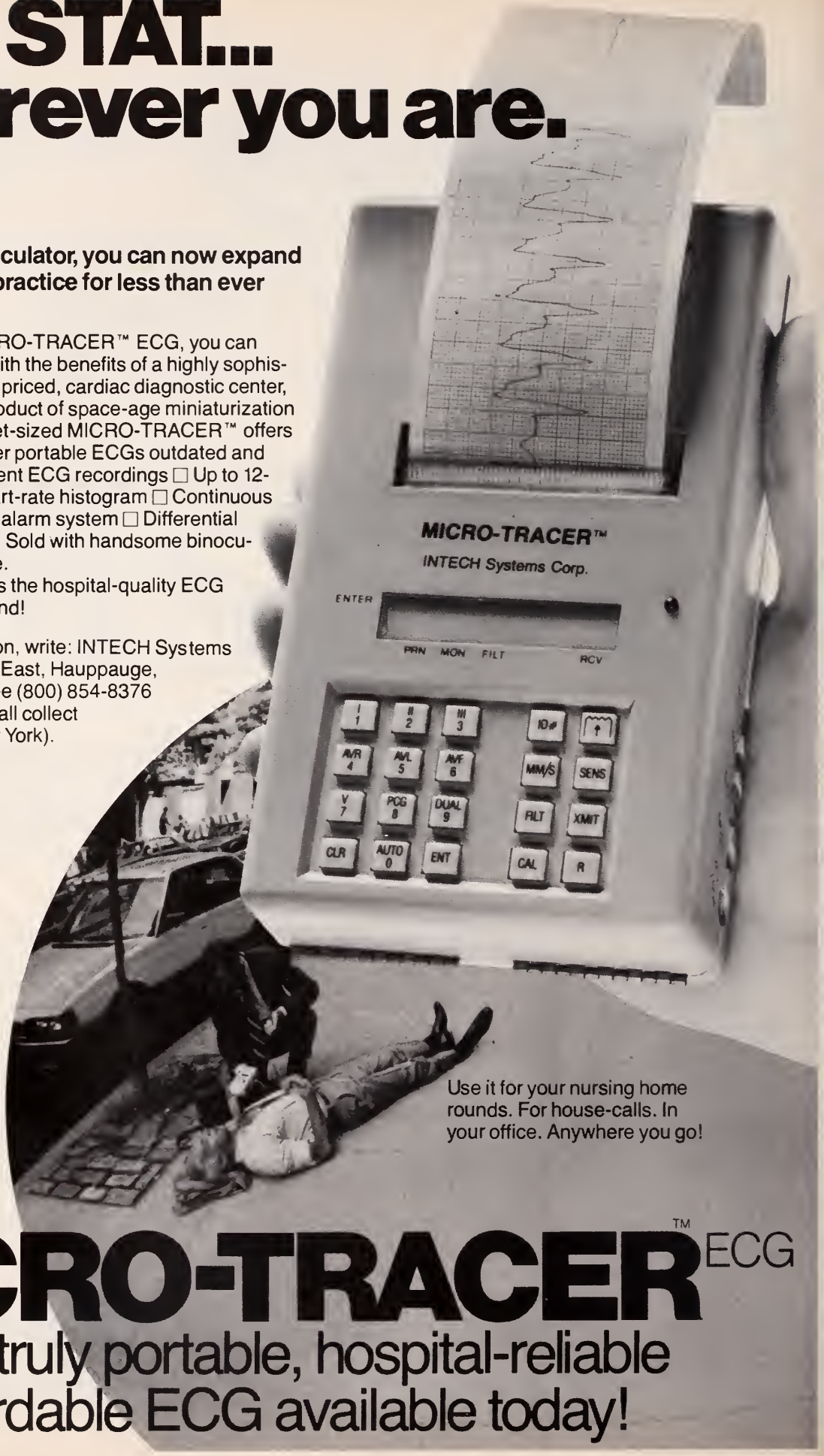

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NEWSLETTER

November 1984

Dear Doctor:

Over the next several months MSMA will develop a computerized medical information system for physicians' offices which will be formally introduced at the May 1985 Annual Session. In order to assure its compatibility with actual practice needs, the system will be designed and operated under the direction of a committee of MSMA physician members.

> Reliability and service will be the cornerstone of the MSMA system, and group discounts will be provided to all users. As an introduction to the MSMA system, a series of three articles on medical information systems begins in this issue of Journal MSMA.

A national relative value scale (RVS) has been suggested by the AMA as an alternative to DRG reimbursement for physicians' services. The AMA is discussing with the Health Care Financing Administration the possibility of developing, with the participation of national medical specialty organizations, a national relative value index.

Development of Health Individual Retirement Accounts is one of the features of an AMA report which suggests combining a modified Medicare program with private sector options as a means of assuring availability of health care services for the elderly and disabled. Along with the health IRAs the report recommends changes in the existing system's benefits, payment methods, eligibility criteria, and financing. Health IRAs would be similar to regular IRAs, with workers receiving a tax benefit for paying into their health account for purchase of private health insurance or for direct payment for medical care. Under the plan, the government's role could be limited to providing such retirees with catastrophic coverage based on ability to pay.

Response has been heavy to inquiries about interest in the MSMA's group purchasing plan for medical office supplies. Savings will be realized through combined volume purchases by the plan's participants. MSMA members who have not yet responded to the recent questionnaire are encouraged to do so.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

Roche salutes
the history of Mississippi medicine

SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.[1]

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An ero of speciolists, chop 5, in Lee RV, Eimerl S *et al: The Physician.* New York, Life Science Library, Time Inc., 1967, pp 107-109

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In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

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- ☐ Early insomnia—91%
  - Middle insomnia—87%
  - Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* edited by Jorvik ME, New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychopharmacology 61*: 217-229, Mar 1979. **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

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Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

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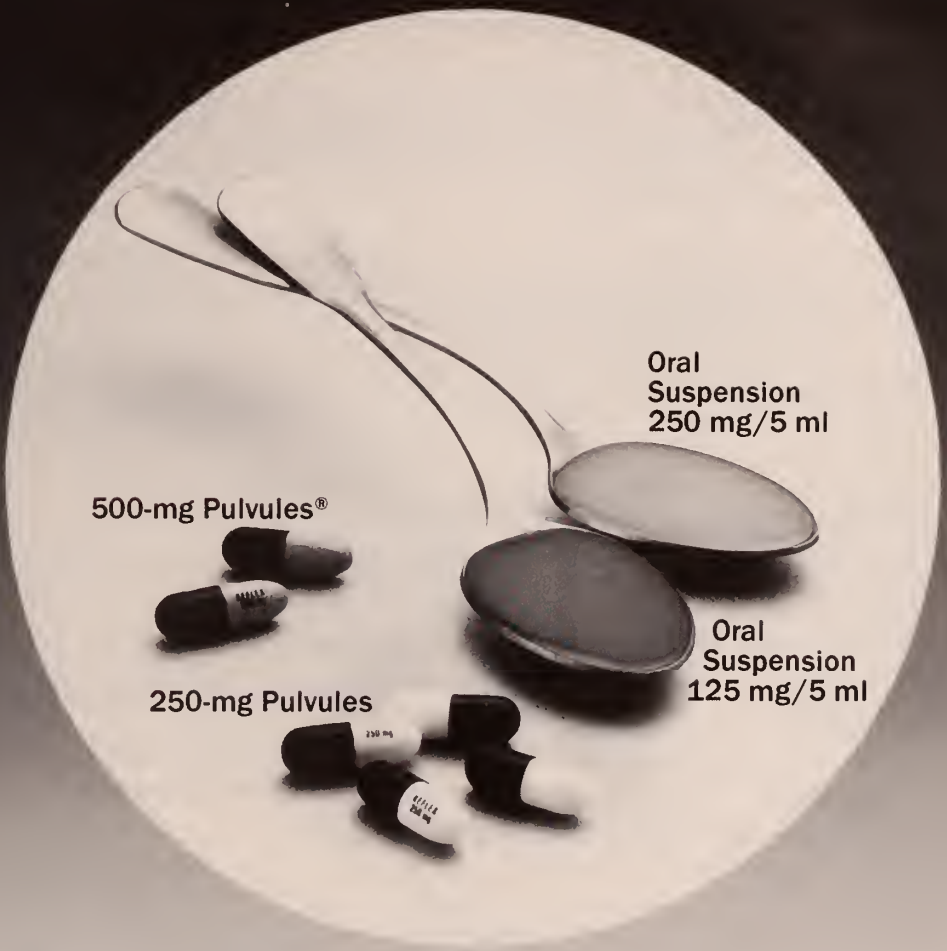

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National Effort Will Combat Medical Quackery

Chicago, IL - Consumers pay an estimated $10 billion per year for bogus health devices and drugs. The AMA has joined in a national public information campaign to warn the public about the problem. Medical quackery can result in lost lives as well as lost money, and education is seen as the best defense. The campaign's goal is to enable the public to distinguish between responsible products and fraudulent or dangerous ones.

Consumer Product Accident Reporting

Washington, DC - Physicians are invited to report injuries caused by consumer products by calling the Consumer Product Safety Commission toll-free at 800-638-8095. The CPSC estimates that 28,000 people die each year as a result of accidents in which a consumer product played a role, either through consumer misuse or product deficiencies. Many accidents are preventable through education or product modification.

Physicians Report More Cost Awareness

Chicago, IL - Cost-consciousness appears to have increased among physicians, according to an AMA survey. Some 69% of respondents said they consider the cost of treatment more frequently now than five years ago. Younger physicians (74%) are more likely than their older colleagues (63%) to think more about costs. By a wide margin (71%) most physicians said costs can be reduced without degrading quality of care.

Cardiac Life Support Course Scheduled

Pontotoc, MS - An Advanced Cardiac Life Support provider course will be held at North Mississippi Medical Center in Tupelo Dec. 7-9. The course meets criteria for 16 hours Category 1 credit. Non-physician registrants (nurses, paramedical, allied health personnel) must have certification by a physician medical director. For information, call North Mississippi EMS Authority, 601/489-2006.

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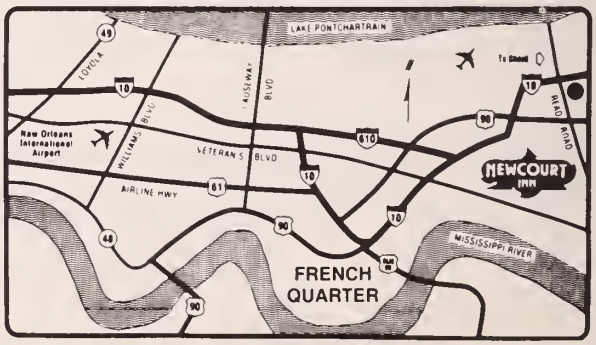

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JOURNAL OF THE MISSISSIPPI MEDICAL ASSOCIATION
November 1984, Volume XXV, Number 11

ORIGINAL PAPERS

Percutaneous Renal Calculi Removal

HUGHES MILAM, M.D., JOHN W. EVANS, M.D., JOHN P. ELLIOTT, M.D., LUCAS O. PLATT, M.D., JAMES O. GORDON, M.D., DANIEL BRASFIELD, M.D., JAMES TRAPP, M.D., and MARSHALL EDMONDSON, M.D.
Tupelo, Mississippi

The authors describe encouraging results in their experience at North Mississippi Medical Center with percutaneous stone removal. They comment on benefits of the procedure, including decreased morbidity and shorter hospitalization time.

PERCUTANEOUS STONE REMOVAL has been developed in Europe over the past decade and recently was introduced to this country with impressive results.[4] In this procedure, a percutaneous tract is developed into the kidney, so that a nephroscope can be inserted. The stone is either removed with a forcep or disintegrated with the ultrasonic probe and the fragments are vacuumed out. The experience at North Mississippi Medical Center is reported for the last several months.

Materials and Method

Any patient is considered for the procedure who has a renal calculus which is not significantly branched, although this is not a limiting factor in some centers.[2] Most of the calculi that were removed were about 1.25 cm. in diameter. The method that is followed closely resembles that developed at the Mayo Clinic by Dr. Segura, except for the tract dilatation.

The patient is admitted one day before stone removal and undergoes a ureteral stent insertion cystoscopically. This facilitates dilatation and visualization of the collecting system for the radiologists. Next, the patient is taken to the radiology suite where the radiologist inserts a percutaneous nephrostomy tube under a local anesthetic. A 14f Malecot nephrostomy catheter is used. Also, a 5 French angiographic catheter is inserted through the nephrostomy tube down the ureter to facilitate guide wire placement.

The following day or the third day, if the nephrostomy drainage is still hemorrhagic, the patient is taken to the operating room where all manipulation is performed with fluoroscopic guidance by a C-arm. There, under a general anesthetic, two guide wires are inserted through the nephrostomy tube into the ureter, if possible, and the nephrostomy tube is removed. One wire is designated a safety wire and sutured to the skin. The second wire is designated the working wire and instruments are passed over it. The tract is then dilated to 28f using the Olbert balloon catheter and Van-Tec renal fascial dilators (see Figure 1). A sheath is then inserted over the dilator. The dilator and balloon catheter are then removed, leaving the sheath inserted into the renal pelvis. The nephroscope is then inserted into the sheath and the pelvis is explored. Initially finding the ureteropelvic junction is helpful for orientation.

When the stone is found, the operator must decide whether to remove it with the forceps or to use the ultrasonic probe. If the stone is too large to remove with the forceps, the ultrasonic probe must be in-

Drs. Milam, Evans, Elliott, Platt and Gordon are engaged in the private practice of urology, Drs. Trapp and Edmondson in the practice of radiology, and Dr. Brasfield in the practice of diagnostic radiology and nuclear medicine.

serted into the working arm of the nephroscope and be placed gently against the stone (see Figure 2). The absorption of ultrasonic energy causes the stone to disrupt and fragment. The fragments are removed by suction which is continuous through the ultrasonic probe (see Figure 3). The pelvis is then re-examined after the probe has been removed and the residual debris is extracted by the forceps.

The nephroscope is removed and a 22f Council tip catheter is inserted over a guide wire into the pelvis.

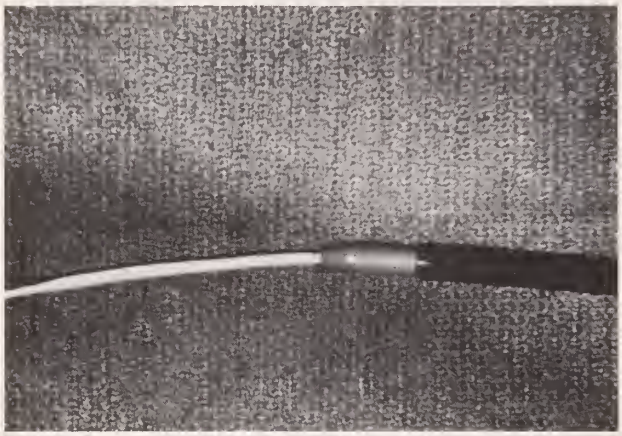

Figure 1. Olbert balloon catheter with fascial dilator and sheath back losses onto the catheter.

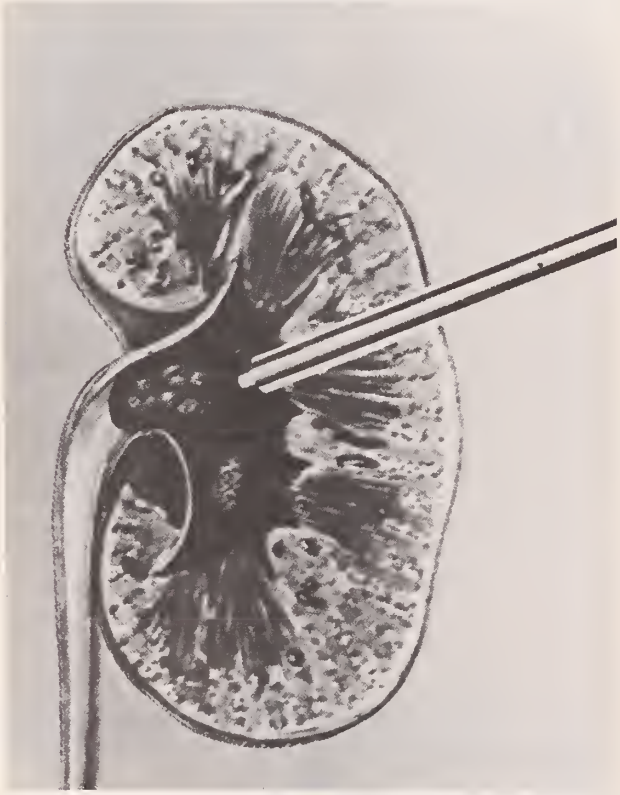

Figure 2. Nephroscope inserted into the kidney next to the stone.

Figure 3. Stone disintegration with the particles being removed.

The catheter is then positioned fluoroscopically and an antegrade pyelogram is performed to confirm positioning and drainage. The catheter is then sutured to the skin and the guide wires are removed. The catheter is then hooked to a sterile gravity drainage system.

Twenty-four hours later a nephrotomogram is made of the kidney to rule out residual fragments, and a repeat antegrade pyelogram is made. If the x-rays are normal, the catheter is clamped and the patient is sent home 24 hours later, if asymptomatic. The nephrostomy tube remains clamped for one week and is removed in the office after an antegrade pyelogram is performed.

Results

The results are summarized in Table I. There were five females and three males, ranging in age from 37 to 71 years. Forceps removal was all that was necessary in three patients. In five patients ultrasonic disintegration and use of the forceps to remove the fragments were needed. In one patient, the nephrostomy tube could not be inserted properly and a classic open pyelolithotomy had to be performed (not listed). The larger stones took between three and four hours to disintegrate. The average fluoroscopy time was about 15 minutes.

A moderate amount of bleeding was encountered during the dilatation of one patient, but this stopped after the fascial dilator sheath was properly inserted into the pelvis. She was given two units of blood and was noted to have a stabilized hematocrit postoperatively.

Another complication resulted in tearing the renal pelvis with the guide wire. This resulted in extravasation of the irrigant and urine. The patient de-

veloped an ileus for two days post-operatively, but this resolved with the nephrostomy tube left open to gravity drainage.

There was a residual fragment left in the lower pole calyx of one patient. This calculus was not removable because of the acute angle encountered, but she passed it spontaneously. In a second patient, a mid-calyceal calculus was not removed because of a stenotic infundibulum, but this patient had a large pelvic calculus which was disintegrated and the patient has been rendered symptom free.

Discussion

The field of endourology has grown dramatically over the last year since the series reported by Segura has shown that percutaneous renal stone removal is not only possible but practical.[3] This development is a culmination of work which was initiated by Goodwin in 1955, with his reporting of percutaneous nephrostomy tube insertion. The development of the ultrasonic lithotrite by Alken led several European centers to experiment with disintegration and removal of larger calculi.[1] Marberger and Wolf Laboratories worked to develop the first marketable equipment for such a procedure which has received much notoriety over the last two years. Finally, the preponderance of endourological seminars over the country for the last year has increased interest at the community hospital level.

The most significant benefit from this new method of stone removal is less post-operative morbidity. The patients are ambulatory in the evening after percutaneous removal early in the morning, and they can be discharged within two days. The nephrostomy tube is the limiting factor in going back to work and it is being removed at seven days, at which time the patient may return to work. This period may shorten as more experience is gained with this procedure.

Also, there is the potential for shorter hospitalization time, which has become more important in the era of diagnostic related group reimbursement. This study revealed an average hospitalization time of 8.75 days, which is not significantly different from open pyelolithotomy. This time does not reflect the true amount of time required for percutaneous stone removal because of co-morbid conditions. The true hospitalization time for this procedure is closer to seven days. Also, as experience is gained, the hospitalization time could be reduced to three or four days.

The location of the calculus is paramount in deciding whether the patient is a candidate for percutaneous stone removal. The easiest stones to remove or disintegrate are those between .5 cm and 1.5 cm located in a small pelvis at the ureteropelvic junction. This is because the stone will not migrate into a calyx or down the ureter. Calyceal calculi are more

TABLE I
RESULTS IN 8 PATIENTS

Patient #	*Stone Size*	*Position*	*Procedure*	*Complication*	*O.R. Time*	*Fluoro Time*	*Hosp. Time*
1	.9 cm.	lt. lower pole calyx	ultrasound forceps	none	2½ hrs.	16.7 min.	8 days
2	1.4 cm	rt. pelvis	ultrasound	hemorrhage	2¾ hrs.	27.4 min.	11 days*
3	1.0 cm.	rt. lower pole calyx	forceps	none	2 hrs.	22 min.	16 days†
4	1.5 cm.	lt. prox. ureter	ultrasound	none	1¾ hrs.	N/A	8 days
5	2.5 cm. .8 cm.	rt. pelvis rt. lower pole calyx	ultrasound forceps	none	4 hrs.	10.8 min.	5 days
6	.8 cm.	lt. upper ureter	forceps	extravasation ileus	1¼ hrs.	9.5 min.	8 days‡
7	1.7 cm.	lt. lower pole calyx	forceps	none	1 hr.	6.9 min.	7 days
8	2.0 cm.	lt. pelvis	ultrasound	none	3 hrs.	14 min.	7 days
Mean	1.26 cm.				2.28 hrs.	15.32 min.	8.75 days

* Admitted for left ureteral stone manipulation (3 days).
† Also had colon polyp resected endoscopically (7 days).
‡ Also had esophageal stricture dilated (1 day).

difficult and almost impossible if the percutaneous catheter does not pierce the affected calyx. Calculi in the proximal ureter have been grasped by the forceps and/or stone basket, but this requires experience.[4, 5] Initially, the stone in the most convenient location should be removed and, as skill improves, an attempt in removing stones in more difficult locations may be made.

The size of the stone is an important factor. The larger stones require ultrasonic disintegration, which greatly prolongs the operating time. Again, the initial attempts at percutaneous removal should be confined to stones less than 1.5 cm.

There has been concern about the effects of prolonged fluoroscopy exposure on the operator. The University of Texas Health Science Center at Dallas carried out a study to define these radiation hazards. This report concluded that 110 procedures could be performed in a year period given an average fluoroscopy time of 24 minutes before the safe limits for eye exposure is reached. The average time recorded for the use of the C-arm in this review was 15.3 minutes, which is well in the safe range. Therefore, fluoroscopy exposure should not be a limiting factor in most practices.

Conclusion

Initial results of percutaneous stone removal in a community hospital have been encouraging. The patient's decreased morbidity and the potential decreased time of hospitalization are important factors to consider in adopting this procedure. The ability for the radiologist and the urologist to cooperate in developing experience is essential for the success of this procedure. ★★★

Dr. Milam: 605 Garfield Street (38801)

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POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: **An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.**

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MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS:
ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

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Metastases To Bone As Primary Sign of Laryngeal Cancer

ANUPAM ROUTH, M.D.,
MYRON W. LOCKEY, M.D., and
BERNARD T. HICKMAN, M.D.
Jackson, Mississippi

Distant metastases from carcinoma of the larynx are rare. The authors report a case in which distant metastasis to bone was the first sign of the disease.

THE INCIDENCE of carcinoma of the larynx is 4.2 per 100,000 population and there is marked male predominance in a ratio of 9 : 1. There were 10,700 new cases of carcinoma of the larynx in the United States in 1978 and 3,700 deaths according to the National Cancer Institute.[1]

The overall survival of all stages is 57%, but increases to 73% for localized disease.[2] Squamous cell carcinoma is the most common histological type.

The usual course of uncontrolled tumor is localized recurrence, whereas the development of distant metastases from carcinoma of the larynx is uncommon. The tumor usually invades or obstructs vital structures within the limits of the larynx or metastasizes to the regional lymph nodes.

There are very few cases reported in the literature of metastases to the bone from carcinoma of the larynx. We report a case in which metastasis to the bone was the initial manifestation of carcinoma of the larynx.

Case Report

The patient, a 54-year-old white male, presented to his local doctor complaining of pain in his right arm which had been present for about four weeks. Although there was no history of trauma, there was marked tenderness over the right upper arm. There was no restriction of movement of the elbow or shoulder. An x-ray of the right arm showed a lytic lesion in the humerus (see Figure 1). This was confirmed with a bone scan (see Figure 2).

The upper arm was surgically explored on March 11, 1981. On palpation during surgery, the palpating finger fell into an osteolytic area at the junction of the middle and distal thirds of the right humerus suggesting that the lesion had eroded through the bone. The osteolytic lesion was biopsied and the histology revealed metastatic non-keratinizing

Figure 1. X-ray showing lytic lesion in humerus.

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squamous cell carcinoma (see Figure 3). Initially the most likely primary site was thought to be the lung. Chest x-ray suggested a left hilar shadow, but whole lung tomograms revealed no abnormality. Bronchoscopy was negative and further workup revealed no evidence of a primary site. However, a suspicious area on the epiglottis was found, and ENT surgeons were consulted.

The ENT surgeons found a friable ulcerative lesion involving the infra-hyoid epiglottis, the anterior commissure, and the right anterior right cord (see Figure 4). The cords were not fixed. Multiple biopsies were taken and the lesion was staged as $T_2N_0M_1$. Histology was invasive squamous cell carcinoma.

The biopsies showed tumor in the right true cord, anterior commissure, inferior epiglottis, and middle epiglottis, but there was no tumor on the left true cord. The patient was referred to Radiation Therapy for further management. The patient was treated with a 4Mv Linear Accelerator to the right humerus and the larynx. He received 4000 rads to the right humerus and 5000 rads to the whole neck and 6500 rads to the larynx. The patient tolerated the treatment well and completed the treatment without any problems. The pain in the arm disappeared. The primary tumor responded very well to the treatment.

Six months later the patient was admitted for tenderness over the left sternocleidomastoid and hoarseness of voice. The patient underwent direct laryngoscopy with biopsy of the hypopharynx. No tumor was seen macroscopically and microscopically. Eight months later the patient developed dyspnea and early signs of superior vena caval syndrome. Tumor was seen in the right mainstem bronchus. Histology was squamous cell carcinoma. It was not possible to determine if this new tumor was a separate primary or metastasis from epiglottic carcinoma. The patient was treated with palliative radiation therapy. Soon after completion of treatment the patient expired. No autopsy was performed.

Discussion

Distant metastasis from carcinoma of the larynx is very rare with few cases being reported in the literature. Garciga[3] reported four cases of metastases from carcinoma of the larynx. One patient developed cutaneous metastases two years after initial

Figure 2. Bone scan shows the lytic lesion.

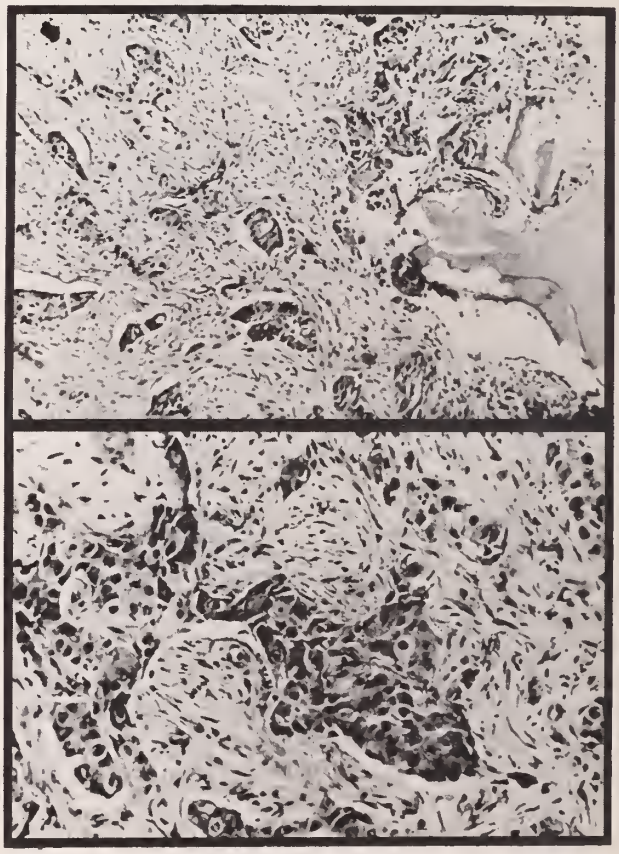

Figure 3. Histology showing metastatic squamous cell carcinoma.

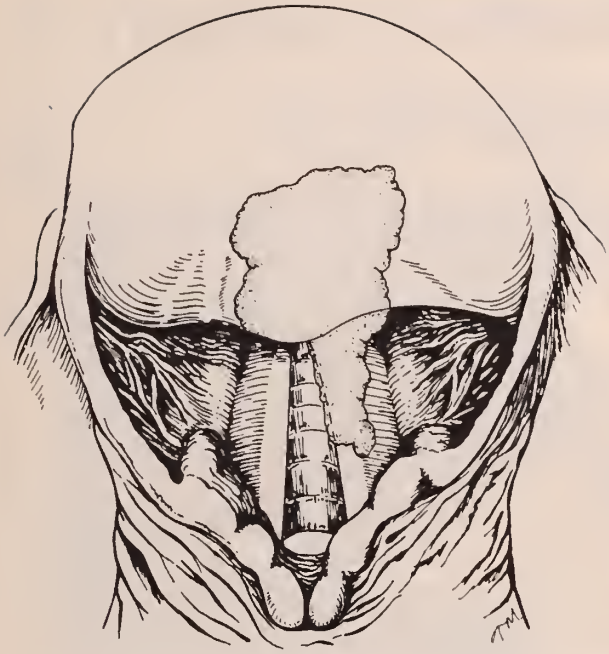

Figure 4. Illustration shows the extent of the tumor.

treatment with radiotherapy. A second patient also developed cutaneous metastases three years after treatment with radiotherapy. A third patient developed skeletal metastases after six months following surgical treatment. A large lytic lesion had developed in the left proximal tibia which was proven by biopsy to be squamous cell carcinoma. In the fourth case, there were cutaneous and bony metastases in the ilium, iliac crest, and scapula.

Uriburu[4] reported a case with metastasis in the hand. This patient had a laryngectomy for carcinoma of the larynx six months previously. The presentation x-ray showed an osteolytic lesion in the middle finger which was treated by amputation. Histologically the tumor was found to be the same as the primary lesion in the larynx.

The present case differs from the above case in that the first symptom was bone pain, and the primary carcinoma of the larynx was asymptomatic and was not diagnosed until later during the workup to find the primary site.

Metastasis to the bone is rare and has been reported after six months to two and one half years after the primary treatment of cancer, but this patient presented in the opposite way, *ie, metastasis was the first sign of the disease.* ★★★

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Severe Neutropenia and Infectious Mononucleosis: Brief Report

RICHARD H. STREIFFER, M.D.
Jackson, Mississippi

The author reports a case of severe neutropenia and profound granulocytopenia in association with infectious mononucleosis.

SEVERE NEUTROPENIA and profound granulocytopenia in association with infectious mononucleosis (IM) is an uncommon though potentially serious development. A previous review of the literature[1] cited only 18 reported cases of such profound granulocytopenia, defined as less than two hundred granulocytes per cubic millimeter, associated with IM. The following case is in addition to those previously reported.

Case Report

A 20-year-old white female university student who was visiting from out of town began to "feel bad" about three days prior to admission when she developed an ulcer in her mouth and soreness in the left buccal area. The day prior to admission she ran a temperature of 102°F, ached all over, had a sore throat and was very tired, prompting her to seek attention at the emergency room. She had no nausea, vomiting, diarrhea, urinary symptoms, abdominal pain, arthralgias, easy bruising or bleeding. She gave a history of being treated five weeks previously by her hometown physician for "infectious mononucleosis," at which time she was ill with fever, sore throat and tender cervical nodes. That physician obtained three blood counts (see chart) at weekly intervals and made the diagnosis of mononucleosis based on the clinical findings and the blood counts. No serologic testing for IM was done then. The patient received doxycycline for 12 days at that time. She improved and felt well for about three weeks until the three days prior to admission.

The patient had been healthy previously except for sinusitis one year before. Family history and review of systems were negative.

Physical examination on admission revealed a flushed, though healthy-appearing, white female in no distress with a temperature of 100.8°F and pulse of 118. There was a mucosal ulcer present on the lower gingiva, and the left buccal mucosa was slightly yet diffusely swollen and tender. There was a slight left tonsillar exudate. She had a large, tender left anterior cervical node. The liver and spleen were both palpable 3 cm below the ribs and slightly tender. There were no skin rashes. Heart and lungs were normal.

Admission blood count showed a total white blood cell count of 2400/mm^3 with no forms from the granulocyte series seen (see chart). Hemoglobin, hematocrit and platelet count were within normal limits. Urinalysis was normal except for +1 protein. Blood urea nitrogen, creatinine, SGOT, bilirubin, and other chemistries were normal. A slide test for mononucleosis was positive, and heterophile antibody titer was positive for infectious mononucleosis at a 1:448 dilution. Blood and urine cultures were negative. Serum IgG was normal, serum IgA mildly low, and serum IgM slightly elevated. Serum protein electrophoresis was normal. Chest x-ray was negative.

A bone marrow aspiration performed just after admission showed mild general hypocellularity with normal megakaryocytes and erythroid series. However, there was a myeloid arrest at the promyelocyte state, without progression of the neutrophilic series to more mature forms. No cells that could be identified as blasts were seen.

The patient was felt to be at risk for sepsis because of the profound granulocytopenia and treatment was

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begun with intravenous cefazolin and gentamycin. The patient continued with a fever as high as 102°F for two days, but her buccal cellulitis began to improve by 48 hours. Repeat blood counts (see chart) began to show rising neutrophil series counts by the fourth hospital day, when at the family's request, the patient was transferred to a medical center closer to her hometown. The clinical course at that center was one of gradual improvement and return of neutrophil counts, both peripheral and bone marrow, to normal over the next week with the only treatment being continuation of previously started antibiotics. Chemistry profile, Coombs, and urinalysis remained normal.

Discussion

Infectious mononucleosis is a common, usually self-limited viral infectious illness in which a large variety of relatively rare complications, hematologic and other, have been reported. Changes in the white blood cells are present in the majority of IM patients. Development of atypical lymphocytes or "Downey" cells is one example, and the appearance of a lymphocytic predominance is another. Yet, development of profound granulocytopenia, defined as less than 200 granulocytes per cubic millimeter, is distinctly rare and has been reported only 18 times previously.

This patient saw her family physician five weeks before admission with a "mononucleosis-like illness," and was treated empirically with 12 days of doxycycline. Doxycycline is not a drug commonly implicated in granulocytopenia, making it an unlikely culprit in this case especially considering the time interval between administration of the drug and the patient's presentation.

Neutropenia, often with a left shift and toxic appearance to the neutrophils and band forms,[2, 3, 4] occurs commonly in association with IM, with the neutrophil count dropping to 3000/mm^3 or less in up to 80% of cases[3, 4] and toxic changes in PMN's being present in up to 95% of cases.[3] However, total white cell count typically is elevated, from 10,000 cells/mm^3 to 30,000 cells/mm^3 because of an absolute increase in circulatory lymphocytes. Hence, there appears the classic picture of leukocytosis with relative lymphocytosis, despite a diminution of the neutrophil count.

Etiology of profound granulocytopenia, is not clear though immunological mechanisms have been suggested. Stevens et al[1] demonstrated opsonic anti-neutrophil activity in the serum of a patient with profound granulocytopenia and IM that varied inversely with the absolute neutrophil count. Evidence for an immune etiology of neutropenia has been demonstrated in other instances[5, 6] and certainly immune mechanisms are well established in certain hemolytic anemias, thrombocytopenias, etc. Unfortunately, immunologic studies were not carried out in this patient.

This patient also demonstrates the previously reported bone marrow finding of a myeloid arrest with no progression of the neutrophilic series beyond the promyelocyte. This myeloid arrest with sparing of other marrow elements has been seen in five of the six prior cases in which bone marrow examinations

TABLE 1

Date	*Hemoglobin (grams)*	*Total WBC per mm^3*	*PMN's per mm^3*	*PMN's Plus Bands per mm^3*	*PMN's (%)*	*Bands (%)*	*Lymphocytes (%)*	*Atypical Lymphocytes (%)*	*Monocytes (%)*	*Eosinophils (%)*	*Basophils (%)*	*Metamyetocytes (%)*	*Myelocytes (%)*	*Promyelocytes (%)*	*Platelets per mm^3*
7/1	12	7900	2370	N.R.	30	N.R.	60	N.R.	10						N.R.
7/7	N.R.	6800	4420	N.R.	65	N.R.	23	N.R.	12	1					N.R.
7/13	N.R.	8800	3168	N.R.	36	N.R.	53	N.R.	10	1					N.R.
8/5#	12.1	2400	0	0	0	0	61	7	32						260,000
8/6	11.8	2600	78	130	3	2**	47	3	44	1					Adequate
8/7	12.0	4200	210	756	5	13**	39	15	25	2	1				Adequate
8/8	12.5	4900	147	735	3	12**	51	1	24	2			2	6	
8/8*	11.5	4600	460	690	10	5	64	N.R.	10	3		3	3	2	404,000
8/10*	11.6	5800	1682	2146	29	8	44		13	1		3	1	1	378,000
8/11*	N.R.	7200	2376	2952	33	8	41		7	1		10			

N.R. — Not Reported.
** — Marked toxic granulation noted.
* — Second Institution after transfer.
# — Day of admission.

have been reported.

All cases have resulted in spontaneous resolution of the neutropenia within a few days with only supportive treatment. However, the implications for serious, overwhelming infection during this vulnerable period of relative immune-deficiency make recognition of the situation, with appropriate follow-up to resolution, of primary importance. ★★★

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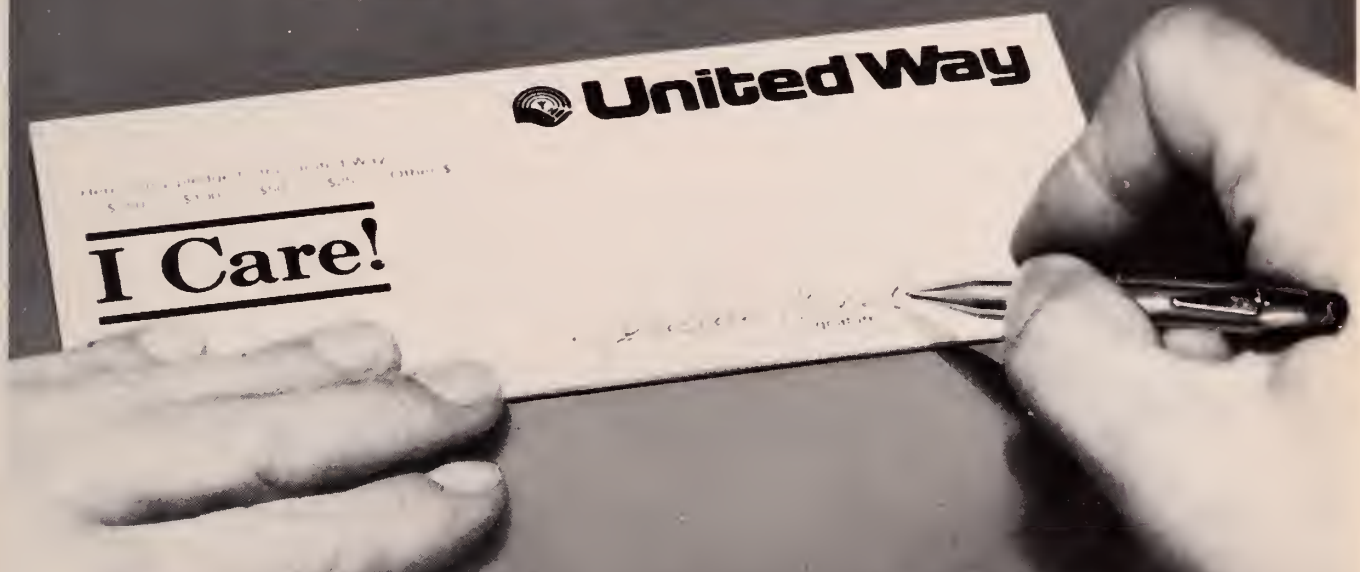

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Case Report XX
Maternal Mortality Study

JOHN C. MORRISON, M.D.
WILLIAM WIENER, M.D.
Jackson, Mississippi

THE FOLLOWING MATERNAL death (Case Number XX) was reviewed by the Committee on Maternal and Child Care of the Mississippi State Medical Association. This maternal death was due to the complications of eclampsia in a young primagravida.

Case Report

This case involves a 19-year-old, gravida 1, para 0 who was admitted to a local hospital with a history of having three grand mal seizures at home. At the time of admission she was approximately 24 weeks in gestation and her prior pregnancy history was unremarkable as it regarded previous hypertension, seizure disorders, or other major disease processes.

During this pregnancy, she had been seen in the local physician's office for five antepartum visits with the first being at 10 weeks gestation. She had had no specific complaints, her routine laboratory assessment had been within normal limits and her blood pressure had been normal on each visit. She had also noted no edema, headaches, or blurred vision and was not proteinuric on any of her visits.

Three days prior to admission she had complained of a headache which was unresponsive to aspirin and had been treated in a local emergency room. The emergency room form revealed that the patient appeared "jittery" and that she had a blood pressure of 130/90. She was treated for a tension headache and given Acetaminophen with Codeine. The headaches continued to worsen and she began to develop non-dependent edema and pain in the right upper epigastric area. She had no other symptoms until seizures developed the night prior to admission.

Upon admission she appeared to be a white obese female in a postictal state, a blood pressure of 160/115, with a pulse of 100 and respiratory rate of 30. She had 4+ reflexes and no positive neurologic findings other than coma. The lungs were clear and the heart sounds were normal. The neck was supple and an abdominal exam revealed a 24cm fundus with positive fetal heart tones at 156 BPM. The extremities revealed 2+ edema and there was marked facial and hand edema.

The diagnosis of eclampsia was made and the patient was administered intravenous magnesium sulfate (4 grams of 10% solution over 5 minutes) and a continuous intravenous solution (10%) at a gram/hour was begun. An ultrasound was obtained which demonstrated a fetus compatible with 24 weeks gestation. The laboratory examination revealed a hematocrit of 40% and hemoglobin of 10.8 gm%, a creatinine of 1.1, a sodium of 138, a CO_2 of 31 and a chloride of 100 and a potassium of 3.7. She had 4+ proteinuria and her blood gases revealed a mixed acidosis.

After 4-6 hours of stabilization the patient seemed to respond by increased urinary output and a reduced blood pressure. A decision was made to deliver the infant. Under general endotracheal balanced anesthesia a preterm 750 gram male infant with Apgars of 5/6 at one and five minutes was delivered. Over the next 12 hours the patient was treated with $MgSO_4$ and intermittent hydralazine but her sensorium did not seem to improve significantly. Some 16 hours after operation she suffered a respiratory cardiac arrest and immediate resuscitative measures were carried out with the restoration of cardiac and respiratory efforts. She was transferred to the Intensive Unit for respiratory management and constant monitoring.

Over the next 48 hours the providers were unable to remove the respiratory support. A CAT scan revealed several large intracerebral hemorrhages principally in the frontal and right lateral aspects of the occipital areas and an EEG revealed little cortical activity. Nearly 72 hours after delivery she experienced a cardiac arrest and was unresponsive to resuscitation attempts. The autopsy revealed widespread cerebral hemorrhage and brain necrosis. The remainder of the examination revealed changes consis-

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Members, MSMA Committee on Maternal and Child Care.

tent with periods of asphyxia and cardio-respiratory support.

Discussion

The findings in this case are all too typical of pregnancy complicated by eclampsia in that there is a highly elevated blood pressure, proteinuria, non-dependent edema and death due to intracerebral hemorrhage. Although most commonly we associate patient neglect with the development of eclampsia, the current case demonstrates patient adherence to recommendations for prenatal care. During the emergency room visit for the headache three days prior to the hospital admission, the blood pressure was slightly elevated and she evinced nondependent edema, facts not evident on prenatal visits. However, because she was obese the latter may not have been noticed, although another tip-off may have been the jitteriness and right upper quadrant pain which may herald impending eclampsia and stretching of the liver capsule.

Frequently we hear that eclampsia before 26 or 28 weeks is unusual when many studies have shown that up to 10-20% of the cases may present prior to this time in gestation. It is also commonly thought that eclampsia does not occur after the first 24-48 hours postpartum. In a recent review, Sabai showed that as many as 40-50% of cases of eclampsia may occur > 48 hours after delivery.[1] Table I shows the various studies in the literature as it regards eclampsia. The results concerning maternal mortality with eclampsia vary widely between the studies. Most would agree however that prevention of further seizures and treatment of $MgSO_4$ is of paramount importance. Nevertheless, most of the studies include cases as illustrated here where the appropriate treatment was given and yet the patient still went on to her demise.

Other well defined risk factors for eclampsia include young age, primiparous, low socio-economic background and prematurity. However multi-parity regardless of gestational age is more commonly associated with maternal deaths from eclampsia. For example, Porapakkham's study revealed that the patients under age 25 had a death rate of 5.5% with eclampsia in contrast to 9.9% for those over 35.[2] Figures from the Massachusetts Mortality Study revealed that the average age of the fatal cases with eclampsia was 32 with 41% of deaths from eclampsia in mothers over 35.[3] Therefore, in contradistinction with our study, many of the studies in the literature reveal that although eclampsia itself may be a problem of the primipara, eclamptic death is more often a problem in the older multipara.

TABLE I
MATERNAL AND PERINATAL MORTALITY ASSOCIATED WITH ECLAMPSIA

Study Authors	*No. of Cases*	*Maternal (%) Mortality*	*Perinatal (%) Mortality*	*Primipara*
1. Porapakkham	298	4.7	21.5	64.8
2. Pritchard	154	0	15.4	85
3. Sibai	67	0	8.6	83
4. Gedekoh	52	5.8	26.0	73
5. Meeks	78	2.6	22.0	73
6. Wightman	43	0	21.2	74
7. Mojadidi	30	6.6	16.6	—
8. Lopez-Llera	704	13.9	26.8	—
9. Chesley	300	9.0	—	—

Severe coagulopathy is another common feature to patients who have eclampsia. Others include concentrated blood volume with raised hematocrits, renal damage and liver failure.[4] Our patient did not evince any of these except for a contracted blood volume and a high hematocrit. In addition, the degree of proteinuria, hyperreflexia or edema is very difficult to document in many of the studies. Our own data from the University of Mississippi[5] also suggests that while the triad of hypertension, proteinuria and edema is frequently present, sometimes the non-dependent edema and proteinuria is marginal or absent and the blood pressure may be only minimally elevated. Therefore, our index of suspicion must be high in patients with *any sign* that might lead one to suspect pregnancy induced hypertension. Delay in the diagnosis and treatment of eclampsia has been associated with approximately half of the fatal cases.

Summary

A maternal death due to cerebral hemorrhage secondary to eclampsia is presented. All of the studies have shown a reduction in the maternal mortality of eclampsia in the past two to three decades. The most significant advance has been the recommendation of $MgSO_4$ as an anticonvulsant medication. Anti-hypertensive agents such as hydralazine, early detection and treatment of disseminated intravascular coagulation, and the use of central cardiopulmonary monitoring systems such as arterial lines and Swan-Ganz catheters have been important advances in the treatment of eclampsia. Nevertheless, the acceptance of early prenatal care by the patients and the heightened index of suspicion by physicians,

particularly those who initially see the patients, will serve to further decrease the mortality in these cases. As in this case, even the most sophisticated intensive care cannot change the course of irreversible brain damage and only heightened index of suspicion coupled with appropriately timed intervention will afford the best outcome for the mother/fetus/neonate. Expertise in intensive care will help us to prevent some of the deaths associated with this devastating problem. ★★★

Dr. Morrison: 2500 North State Street (39216)

Acknowledgement

Supported in part by the Vicksburg Hospital Foundation.

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T U R N

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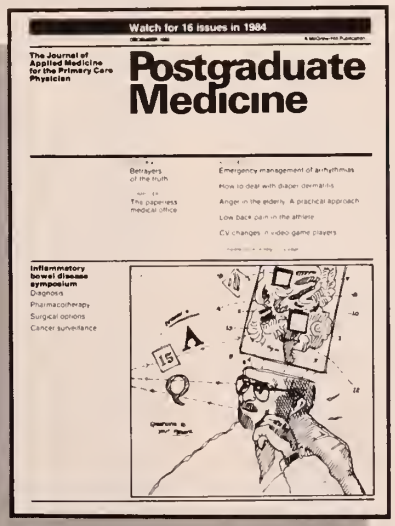

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SPECIAL ARTICLE

Computer Technology and the Medical Profession

STEPHEN AHRENS, Ph.D.
Jackson, Mississippi

Over the next several months the MSMA will develop a computerized medical information system for physicians' offices. A committee of physicians will design the program to assure its compatibility with actual practice needs. This article is the first of three on the subject of computerized information systems and the practice of medicine.

When Susan Jones, an 11-year-old sixth grader, fell off the school swing she landed on her arm, hit a bicycle rack, and severely lacerated her jaw. She was rushed to the emergency room of a nearby hospital, x-rayed, treated by the emergency room physician, and admitted. Orthopedic and plastic surgeons were called in to treat Susan's broken arm and lacerated jaw.

After Susan's hospital stay and recovery, her mother made a count of the forms, bills and checks that had to be filled out and processed on behalf of Susan. All in all, Mrs. Jones counted 62 documents that were processed as a result of Susan's accident. These documents flowed between Susan's physicians, school, parents and insurance companies. Not included was the additional paper work generated by a subsequent lawsuit filed by Susan's parents alleging faulty school playground equipment.

This incident was based on an actual account which occurred in southern California in 1982. It serves to show us that we are rapidly becoming a society of multiple forms processors, detailed record keepers, and never ending paper shufflers.

What is the answer to this overwhelming crush of paperwork? To the increased demand for more detailed information arrayed in increasingly more complex ways? To the need for safely storing and meaningfully organizing decades of seemingly burdensome, trivial information for one's own self-protection? To many, the answer is computerization.

While industrial technologists claim that the amount of paperwork will decrease, they also point out that the amount of information needed will increase and become even more complicated. Tomorrow we will have to rely on machines to process insurance forms, pay medical and dental bills electronically, and store receipts for later income tax filing (more forms).

Do we want to use and trust machines to such an extent? It is beginning to look as if we no longer have a choice.

This monograph will serve as the first of three dealing with the medical profession and computers. The thrust of these articles is threefold: (1) to overview computer technology and processes; (2) to develop an awareness of what the market holds (current and future); and (3) to design a computer system for a typical practitioner.

Achieving Computer Literacy

Computers are supposed to solve problems and to make life easier. However, too often they just cause more problems and eventually end up on a shelf in an attic collecting dust. Why?

The answer lies in people's expectations. People were led to believe that computers were easy to use and fun; more importantly, they were convinced by the media, educators, colleagues, industry, friends and relatives that they were *necessary*. All of which

Dr. Ahrens is director of information services of the Mississippi State Medical Association.

is complete nonsense. You can live without a computer. You can have fun without a computer. You can thrive and profit without a computer. And it is not as if being a "computer illiterate" is having a communicable disease. Besides we do not even know what computer literacy actually means . . . some people just think they do. For example, I have talked with people who have 14 years experience on Data General Equipment who understand an RDOS or AOS environment but have no comprehension of IBM's OS CICS or CMS utilities or the advantages of VSAM over ISAM over BDAM files. So what? Much worse is the person who expounds on this COBOL tape/RPGII/RAMDAM operating system (utter nonsense) with the same steely-eyed conviction found in our more ardent MSU football fans.

So we really do not need to know anything about computers, right? Yes and no. If it "ain't broke" and you "don't intend to fix it" and you've got the proverbial "old ladies in tennis shoes" to handle your billing and filing needs, and it works, and you are happy . . . then you do not need a computer. On the other hand, if you are having a cash flow problem, accounts not being billed, payrolls not being met, patients not being scheduled properly, etc., then you should review your office managerial techniques first and, perhaps, improve on them. Secondly, if the need is there — consider two options: (1) computerize your office with an in-house system or (2) have a service bureau do it for you. (Author's note: The third article in this series will deal exclusively with in-house systems and service bureaus.)

Computer Systems

Now to the basics. Computer systems are integrated parts composed of machines (hardware) and programs (software) and classified into the following components: arithmetic/logic; control; input devices; output devices; and storage (main and auxiliary). The environment under which this all works is known as an operating system.

Operating systems (the control component) can be table driven (eg, FOS-HP, OS-IBM, UNIX-AT&T) or disc resident (MS-DOS, CPM, DOS-IBM, RDOS-D.G); support multiprogramming, multitasking, spooling (which means that more than one person can be on the system at a time or that the system is available when printing a job); menu driven; and user-friendly (Macintosh/Lisa DOS is; UNIX is not).

An operating system is simply a task manager. It tells the computer where to store files; when, where, and how to execute programmable code; orders priorities; accounts for disk space availability; and, in general, is the software (firmware) that runs the show. The show is always run the same way: input, process, output. Regardless of the application, you get information into the computer (input), the computer interprets/compiles the instructions and executes them (process), and then the computer puts the processed information out to a file or device (output). What else do we need to know? Actually not a whole lot. Consider the following progam written in BASIC:

```
10  REM PROGRAM TO ADD ANY TWO
    NUMBERS
20  INPUT "WHAT IS THE VALUE OF X" X
30  INPUT "WHAT IS THE VALUE OF Y" Y
40  LET Z = X + Y
50  PRINT "THE SUM OF THE TWO NUM-
    BERS IS =" Z
60  END
```

In the program, lines 20 and 30 receive *input* for the random variables "X" and "Y"; the input is *processed* in line 40 and the resultant sum is moved to the "Z" variable (data name or field); and finally the answer is *output* in line 50. Essentially all programs follow this top-down flow of logic.

To get this program to run on a computer one would simply type in the statements on an input device like a terminal keyboard (CRT-cathode ray tube, monitor, screen, scope, VDT-video display tube, etc — they all are the same thing) and then save the program on an auxiliary device such as a disk drive. Next they would execute the program, at which time the operating system would take over.

The first step would be to convert the source code (the BASIC program) into object code (machine language-0's and 1's) and then execute the object code in main memory (the processor, cpu, box, Z80, INTEL 8088, Motorola 68000, etc) and, finally, output to the screen with the first prompt found in line 20.

Two questions that remain unanswered are what is machine language (object code, binary, etc) and why do we even need to worry about it? I will answer the last question first. Generally you do not have to worry about it; however, if you ever purchase a program in machine language — *you can never modify it!*

Now the first question . . . why the machine language translation. First, computers are limited to very simple tasks. In fact, a computer is only able to indicate two possible states or conditions. Like the ordinary light bulb, it is either on or off. Similarly in the computer the transistors, circuits, and other com-

ponents are either conducting or they are not; specific areas on plastic tapes are magnetized or they are not; pulses are present or they are not. This on or off status is communicated to the computer in binary digits known as bits. The bits are then arranged into bytes (8 bits) or words (16 bits) and used to develop both complex and simple sets of instructions called subroutines, routines, and programs (note: to simplify things a byte of information is simply a character like the letter "A"; eg, "LSU" is equal to 3 bytes).

The basic concept of the computer is that it is a machine that is capable of doing two fundamental operations at very high speed. First, it is able to obtain a piece of information from a storage area and perform a function as directed by the information it obtains; secondly, based on its current status, it is able to ascertain where to obtain the next piece of information that will give it further direction. This concept is the key to the operation of all digital computers, and while it is a simple concept, it can be built upon to arrive at all the complex operations computers of today can perform.

TABLE 1
FUNDAMENTAL COMPONENTS OF A DIGITAL COMPUTER

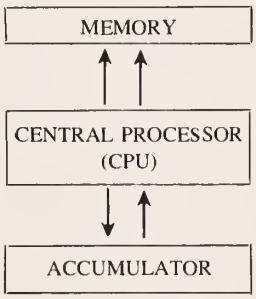

Table 1 shows three interconnected boxes which represent a basic microcomputer. The uppermost portion of the diagram is labeled the memory, the middle portion is the central processor unit, and the lower part is the accumulator. The correlation between the components is extremely simple.

The Memory is a storage area. It is a place where instructions and data can be stored for long lengths of time. The memory can be accessed. Instructions and/or data can be taken out of memory, operated on, and replaced. New data can be put into the memory.

A memory that can be read from as well as written into is called a read/write memory. A read/write memory is often referred to as RAM (random access memory). A memory that is never written into, is abbreviated as a ROM (read only memory). For the present discussion the term "memory" will refer to read and write memory (RAM). The utilization of read only memories, as a general rule, refers to the operating system and other manufacturer type software (firmware) or utilities (such as a COBOL compiler).

The Central Processor Unit (CPU) in a computer is the section that controls the overall operation of the machine. The CPU can receive (fetch) instructions or data from the memory. It is able to interpret the instructions it fetches from the memory. It is also able to perform various types of mathematical operations. It can also return information to the memory to make deposits of data into specific registers of the memory. The CPU contains a control section that enables it to remember, for future sequential access, the location(s) in memory where it has finished performing an operation. Or, if it is directed to do so, to jump to a new area in memory from which to continue fetching instructions.

The Accumulator is a temporary register or manipulating area which is used by the CPU when it is performing operations, such as adding two numbers. One number or piece of information can be temporarily held in it (stacked) while the central processor unit goes on to obtain additional instructions or data from memory. It is an electronic scratch pad for the CPU.

Files and Data Bases

Today's demand for accurate, timely information based on current data has never been greater. In order for raw data to be converted into information for decision making it must be arranged into a machine readable form and stored into the system as a file.

Files are nothing more than a related group of data structured in some meaningful way. Files are subdivided into records and fields which consist of data elements. Consider the file in Table 2.

TABLE 2
SAMPLE FILE STRUCTURE
FILE = DUMMY-DATA

*Name**	*Age**	*Weight**	*Height**
Joe†	22†	222†	72†
May	24	111	63
Jim	34	186	71‡

* Fields.
† Records.
‡ Data Elements.

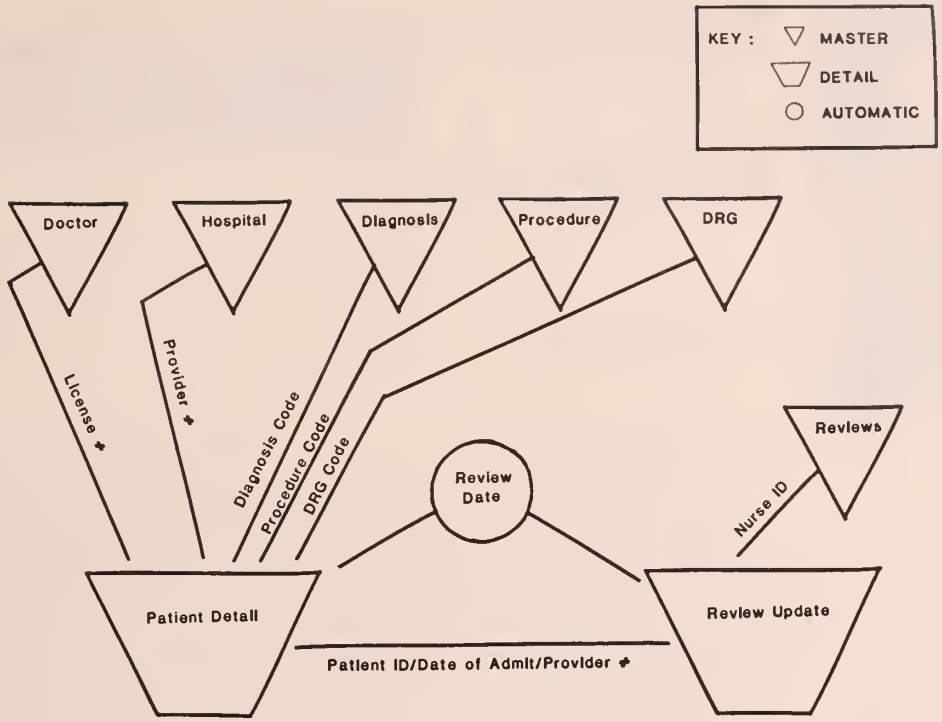

Figure 1. Sample Data Base

The file dummy-data consists of three records; one each for Joe, May, and Jim. It has 4 fields or variables (Name, Age, Weight, and Height) and 12 data elements. The file is considered to be fixed length as opposed to variable length and flat as opposed to hierarchal or layered. In other words, all the records are of the same length and contain data related to the same fields.

The current state-of-the-art allows for files to be treated almost as records through a data base process. A data base is a collection of logically related files that are linked together through chains or keys. Figure 1 shows a sample data base structured around a patient claims reporting procedure that could be used by a hospital or medical insurance company.

The advantages of data base are numerous: ease of programming, ease of updating and retrieval; ease of maintenance; and, most important, the linkage factor or the ability to produce reports by any permutation(s) through the use of keys. Under this example, reports can be generated by over 350,000 combinations: Hospital by Patient by Doctor by DRG, Doctor by DRG by Hospital, etc.

Summary

This introductory article intends to impart information about computers in a general and nontechnical manner. Readers should not be alarmed if they do not fully understand all of it. Five years from now computers will be as simple to use as a microwave oven. Knowledge of file structures, programming and complex operating systems will be as useful as the ability to speak Latin. However, any person learning a new skill must, of necessity, learn the vocabulary of the discipline in order to proceed to any great extent. One might think that it would be easier if everything were written in plain everyday words, but the truth of the matter is that specialized vocabularies do serve several useful functions. For one thing, they greatly shorten the time that it takes to communicate ideas or concepts. Also, the limitations of the English language often result in a given word having a special meaning when it is used in the context of a particular subject.

It is hoped that the material contained herein will enlighten the reader, dispel some of the myths about the subject one may have acquired in the past, and help put computers in the perspective in which they belong. They are valuable tools which will be used increasingly in the future — especially in the area of home medicine and telecommunications — perhaps the most beneficial and potentially the most dangerous area to not only the world of medicine, but to our entire existing social structure as well. In the long range future, it appears that the question will no longer be: "Will I or will I not computerize?" The more compelling question may be "When?" ★★★

The President Speaking

Mirror, Mirror on the Wall

Ellis M. Moffitt, M.D.
Jackson, Mississippi

Both public and private spending on health care have grown much faster than the economy, and in the last year over $350 billion was spent on health care. Health care costs rose 11.9%, while general consumer prices rose only 3.9%. Spending for health care now accounts for over 10% of the GNP.

This subject has had great visibility and numerous surveys have shown a high level of public concern. Until now no major survey has looked in any detail at the likely reactions of the public, employers, unions, health care providers, and the health insurance industry to the range of options now being debated.

To fill that gap, the Equitable Life Assurance Society of the United States commissioned Louis Harris and Associates to conduct a nationwide survey on this issue. It found:

1. Seventy-five percent of the American public views the health care system as needing major changes. This view is shared by the majority of employers, insurance executives, unions and by a marginal majority of hospital administrators. The one exception to this consensus lies with the medical profession: A clear majority of physicians who head the medical societies believe that the health care system works pretty well and that only minor changes are needed to improve it.

2. Cost related and access related changes head the list of changes in the health care system considered most important by the American public and union leaders. The other professional groups acknowledge the need for cost related changes, but they also emphasize public education regarding medical programs and costs. The primary change sought by physician leaders is less government interference and regulation. The public's concern about access centers around care for the elderly.

3. The 14% of the population who did not obtain medical care in the 12 months prior to this survey include sizable numbers (32%) of the uninsured and the unemployed (28%). The primary barrier to obtaining needed medical care is the cost of this care.

4. While a slight majority of the American public are dissatisfied with the total cost of health care as well as out-of-pocket costs, their criticisms are focused mainly on the cost of hospitalization and cost of laboratory work and x-rays done outside hospitals and clinics. The view that hospital costs are unreasonable is shared by

(Continued on page 307)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXV, Number 11
NOVEMBER 1984

Bewildered in Mississippi

Dear Advice Columnist: For years my parents have been dependable, concerned, and supportive people. Now they seem to have become self-serving and not the sympathetic, responsive people they once were. No longer can I depend on them to be an effective voice for me in government and my buffer with the economic and political influences on my life. At times they require more and more money and seem to do less and less for me.

Bewildered, MS.

Dear Bewildered: Times have changed. You children have grown up now and are having to meet the challenges of this changing world. Just as you aren't perfect children, your parents have had problems also. In the past they have tried to be everything to each one of you. As they have gotten older and the complications of life have multiplied, they have found it necessary to enlist your help in doing many of the things that they would have liked to have done for you but are now not able to do. Don't look at this "Old Age" as senility, for as they have gotten older they have grown wiser, more sophisticated and better able to deal with your problems. Remember, when life and times are hardest that is when family ties are and should be strongest. Your AMA and the rest of the family love you and care about you.

Joseph E. Johnston, M.D.
Associate Editor

JOIN MPAC TODAY

THE PRESIDENT SPEAKING

(Continued from page 306)

an overwhelming majority of union leaders, corporate benefits officers, and insurance executives, and by a significant majority of physician leaders. Even among hospital administrators, 40% view hospital costs as unreasonable.

5. There is very little consensus on the main cause of increased spending on health care. While slightly more than 40% of the American people view this escalation as due to the increasing cost of the same services, one-third of this group blame the use of new and more expensive treatment and equipment. Physician leaders and hospital administrators view the latter reason as the primary cause of escalating expenditures.

6. The health care system as it is today does little to encourage price competition. Only 16% of the American public have selected a doctor on the basis of lower fees. Comparison shopping for prescription drugs is easier than shopping for health insurance, doctors, or hospitals. Shopping for laboratory tests or x-rays is viewed as difficult by the majority of the American public.

7. Large majorities of the American public and all of the professional groups except the physician leaders agree that the lack of competitive pricing among doctors, hospitals, or nursing homes contributes to the rise in health care spending. On the other hand, there is general consensus that as long as third party payors assume all or most of the cost of health care, there is no incentive for patient or providers to cut spending or costs.

8. The American people and most professionals recognize that programs and practices that benefit them are also a source of inflation in health care spending. Majorities in all groups mention the following as contributing to cost escalation: the in-

THE PRESIDENT SPEAKING

(Continued)

creased availability of employer paid health insurance, hospitalization for minor ailments, the growth of malpractice suits, people staying in hospitals longer than is necessary, the aging of the population, increased availability of government funded programs and overuse of tests by doctors. While majorities of respondents in all groups recognize that "one of the problems in health care is that there is no real competition to keep prices down," only 27% of the physician leaders agree with this view.

9. The American public is remarkably willing to accept a broad range of cost containment policies, including those that would increase out-of-pocket costs to the public and minimally curtail freedom of choice among health care options. The proposals the public considers most acceptable are: alternatives to use of hospitals for minor surgery, tests, or the treatment of the chronically ill, increased cost sharing in the payment of health insurance premiums and increased deductibles, diagnosis-related cost caps on hospital and physician fees, requiring second opinions on non-emergency surgery, insurance rate incentives for preventive care, prepaid plans and preferred provider plans, and using low cost alternatives to physician and hospital care.

10. Professional groups have varying perspectives on the cost-containment proposals. Union leaders, corporate benefits officers and insurance executives generally share the views of the American public, and they are willing to accept all of the proposed changes in the health care system. Hospital administrators are generally willing to accept changes in the health care system in the interest of cost containment, even if the changes mean a reduction in hospital use or a restriction on the fees charged by the hospital. Physician leaders are the least willing of all groups surveyed to accept — or even to recognize as effective — changes that are likely to adversely affect the financial incentives for their profession.

11. Corporate executives whose organizations have had experience with various cost-containment measures are more likely to judge them as effective than are those who have had no experience with these measures. This is particularly true for programs that require increased cost-sharing by employees and for those that provide better coverage for lower cost health care options, such as home care for the chronically ill and the use of nurse practitioners, midwives, and physician assistants.

12. One policy that is rejected by the majority of respondents in most groups as ineffective and unacceptable as a cost-containment measure is the often discussed individual tax on a portion of the employer-paid health insurance premiums. The physician leaders are the only group in which a clear majority find this proposal to be both effective and acceptable.

13. The majority of the American public and the majorities of all the professional groups disapprove of the practice of shifting costs from Medicare patients to other patients.

14. The American people (including the unemployed) and corporate benefits officers reveal a marginal reluctance to support health care benefits for the unemployed if such benefits result in higher direct or indirect cost to other people. Physician leaders, insurance executives, and hospital administrators, on the other hand, favor providing these benefits.

15. The majority of the American public are remarkably aware of and concerned about problems related to the health care coverage and health care services.

Sometimes it is good to see ourselves as others see us and think about us. One thing we must do is get a handle on the rapidly rising cost of medical care. It is amazing to me that the public has the perception of health care costs that it does. What is even more amazing is how little we perceive the public and their attitudes toward health care costs. The public has solutions. Read section 9, 10, and 11 above. The physician leaders do not. The leadership of the Mississippi State Medical Association in the coming months hope to unveil to you methods of being competitive and controlling costs.

117th Annual Session
May 15-19, 1985
Biloxi, MS

COMMENT

Not a Vendor

What makes a good physician? This question has been asked over and over — especially now that so much emphasis is being placed on educating primary physicians to meet people's basic health needs. It is certain that educating a person to be a "primary" physician does not necessarily make her/him a good physician. There is general agreement among thoughtful educators that a good physician should be intelligent, knowledgeable about diseases, skilled in healing, well read, aware of new developments, and empathetic. These are all essential qualities, but not, I think, the only ones. A good physician also needs some education outside the medical field, for medicine cannot thrive in a vacuum. Moreover, a good physician must be able to communicate his/her value to patients. The purpose of this is not to allow the physician to wallow in self-conceit but to encourage patients to trust and respect the physician. Even more important, the physician must communicate a strong awareness of the patient's personal value. It is not enough simply to be impressive: a distinctive figure who commands attention when walking down Main Street or entering a room is not necessarily a good physician. Love and caring — perhaps it is these that make a good physician? They are noble attributes and, I feel, necessary ones, but are they enough by themselves? You can literally love your patient to death unless you have a solid grasp of medical knowledge and are willing to share it. Yet at the same time all the knowledge in the world is useless if you lack the spirit to get out of bed to administer and minister to those in sickbeds.

What makes a good physician? I have no quick and easy answer. Perhaps each of us must answer the question for him/herself. The answer probably lies in the living of each day in the profession and in the breath and life of relationships over time.

Whatever the definition of a good physician is, there is one thing it is not. A good physician is not a vendor, selling services for a price.

B. Lewis Barnett, M.D.
Charlottesville, VA

(Editor's Note: The above article was submitted by Dr. Richard L. George of Columbus, and is reprinted with the permission of Continuing Education for the Family Physician, *Le Jacq Publishing Inc., 53 Park Place, New York, NY 10007.*

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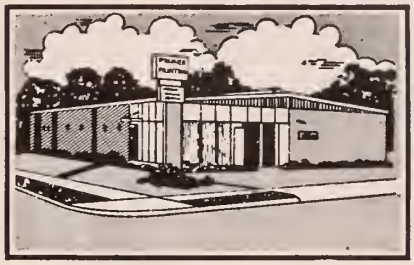

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Procedures Now Available For Living Will Declarations

Mississippi now has a law that allows for filing a "Living Will."

Passed in the 1984 Legislative Session, the law allows any Mississippi resident aged 18 years or older and mentally competent to voluntarily express his wish to withdraw life-sustaining mechanisms should he suffer a terminal physical illness.

"Living Will" declarations can be filed with the Mississippi State Department of Health Division of Public Health Statistics. Procedure forms for filing will be available after October 1 in each county health department and at all hospitals. Physicians, attorneys, and other individuals may request filing forms from the agency by writing "Living Will," State Department of Health, P.O. Box 1700, Jackson, Mississippi 39205-1700.

One who files a "Living Will" may cancel the declaration by filing a revocation form. The procedures package contains the revocation form.

The declaration is as follows: "I, being of sound mind, declare that if at any time I should suffer a terminal physical condition which causes me severe distress or unconsciousness, and my physician, with the concurrence of two other physicians, believes that there is no expectation of my regaining consciousness or a state of health that is meaningful to me and but for the use of life-sustaining mechanisms my death would be imminent, I desire that the mechanisms be withdrawn so that I may die naturally. However, if I have been diagnosed as pregnant and that diagnosis is known to my physician, this Declaration shall have no force or effect during the course of my pregnancy. I further declare that this Declaration shall be honored by my family and my physician as the final expression of my desires concerning the manner in which I die."

Two witnesses must also sign the declaration form.

The filing fee of $10 helps cover administrative costs; no fee is charged for filing the revocation form.

Questions about the "Living Will" or requests for a procedures package may be addressed to "Living Will," P. O. Box 1700, Jackson, Mississippi 39205-1700.

AMA-ERF Campaign Benefits UMC

Barbara (Mrs. Terrell) Blanton, right, president of the Mississippi State Medical Association Auxiliary, and Susan (Mrs. John) Mladineo, state chairman of the auxiliary's annual American Medical Association-Education and Research Fund campaign drive, met with University of Mississippi Medical Center vice chancellor Dr. Norman C. Nelson to discuss the uses of money raised through the campaign. In 23 years, AMA-ERF gifts have totaled nearly $350,000 and have been used most recently for summer student research awards, to help meet students' emergency financial needs, and to help send students to national meetings to represent their school and present results of their research.

UMC Announces Enrollment Figures

Enrollment for the 1984-85 academic session at the University of Mississippi Medical Center has reached a total of 1,737 students. Figures included 1,476 students from Mississippi, 231 students from 33 other states and 15 students from 14 foreign countries and one territory.

Students were enrolled in medicine, dentistry, nursing, health related professions, graduate medical sciences and other medical science related programs and post graduate programs.

A total of 524 students were enrolled in the School

of Medicine, 151 in the School of Dentistry and 246 in the School of Nursing.

The School of Health Related Professions enrolled 352 students. The total number included three in cytotechnology, 26 in medical records administration, 25 in medical technology, 27 in nurse anesthesiology, 47 in physical therapy, 43 in dental hygiene and 181 in respiratory therapy.

There are 75 students enrolled in the graduate program in medical sciences and 56 in other medical science-related programs. The number of postgraduate students reached 333, an increase of 14 students from last year.

UMC Schedules Perinatal Course

The University of Mississippi Medical Center will present its sixth annual perinatal postgraduate course December 2-4, at the Holiday Inn Downtown in Jackson. Physicians, nurses, social workers, dietitians, technicians and consumers interested in the delivery of health care to the mother, fetus or newborn are invited to attend.

The course, designed to support the team or multidisciplinary approach to solving perinatal health care problems, will include lectures on recent scientific developments in the area of perinatal medicine. Information that can be used in a practical clinical setting will be provided through the lectures and panel discussions.

A special session for nurses will be held December 2 on infertility, adolescent pregnancy and perinatal/neonatal loss and grief. The general session begins December 3, with discussions on the pathogenesis and therapy of neonatal apnea, management of postpartum infections, supporting the family beyond maternal needs, contemporary applications of perinatal ultrasound, history of RDS and role of artificial surfactant, and special perinatal risks in women younger than 18 and older than 40. Topics for discussion on December 4 include screening for perinatal infections, the symptomatic PDA in hyaline membrane disease, the biophysical profile of the fetus, recent developments in thermoregulation, bacterial infections during pregnancy, the diagnosis and management of herpes during pregnancy, and newborn respiratory distress.

Joining University Medical Center faculty speakers are guest speakers Doris Barnette, director of the family planning branch of the Division of Maternity and Family Planning in the Bureau of Personal Health Services of the Mississippi State Department of Health in Jackson; Dr. Robert B. Cotton, associate professor of pediatrics and chief of nurseries at Vanderbilt University School of Medicine in Nashville, TN; Dr. John H. Grossman III, associate professor of obstetrics and gynecology and microbiology, and director of the division of maternal-fetal medicine at George Washington University School of Medicine and Health Sciences in Washington, DC; Mary Francis Haire, OB regionalization coordinator of the department of obstetrics and gynecology and administrative coordinator of the maternal-fetal division at Vanderbilt University School of Medicine in Nashville, TN; Dr. John Kattwinkel, professor of pediatrics and director of newborn services at the University of Virginia School of Medicine in Charlottesville, VA; Dr. Lawrence D. Platt, associate professor of obstetrics and gynecology at the University of Southern California School of Medicine in Los Angeles; and Dr. John L. Sever, professor of pediatrics at Georgetown University Medical School in Washington, DC and chief of the infectious diseases branch of intramural research programs for the National Institute of Neurological and Communicative Disorders and Stroke of the National Institutes of Health in Bethesda, MD.

Course sponsors are the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine, the Department of Pediatrics Division of Newborn Medicine, the Department of Family Medicine and the Division of Continuing Health Professional Education at UMC. Dr. John C. Morrison, professor of obstetrics and gynecology and director of the division of maternal-fetal medicine, and Dr. Philip G. Rhodes, professor of pediatrics and chief of the division of newborn medicine, are course coordinators.

Registration fees are $200 for physicians and $90 for others. The American Medical Association will award 11.75 credit hours to physicians in Category I of the Physicians Recognition Award.

For a brochure and registration information, contact Continuing Education at the University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505, or call (601) 987-4914.

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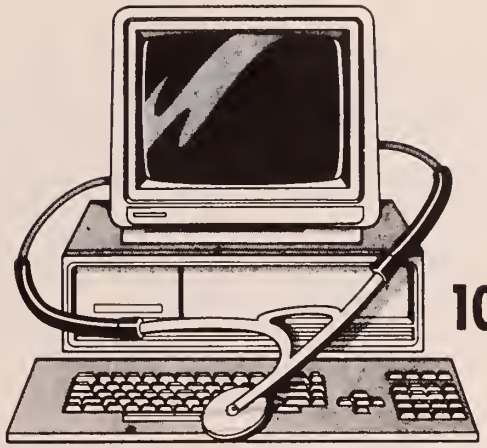

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PERSONALS

James Achord of UMC was visiting professor at Norwalk Hospital, Yale University School of Medicine, in Norwalk, Connecticut, in September.

Bill Austin of Forest was honored at a reception sponsored by the S. E. Lackey Memorial Hospital Auxiliary upon his retirement after 42 years of practice.

D. F. Carlos announces the opening of his office for the practice of general psychiatry at 130 Fleitas Avenue in Pass Christian.

Wallace Conerly of UMC spoke at AMA-ERF luncheon meetings in Greenwood, Tupelo, Hattiesburg, and Vicksburg.

Edgar Draper of UMC chaired a committee on religion and psychiatry during a meeting of the American Psychiatric Association in Washington, DC, in September.

James Hardy of UMC lectured at the First Annual G. Rainey Williams Surgical Symposium in Oklahoma City in September.

Martin I. Herman of Tupelo has been elected to fellowship in the American Academy of Pediatrics.

Phil A. Hooker announces the opening of his office for the practice of allergy and dermatology at 517 University Drive in Starkville.

John F. Johnson of Pascagoula was appointed chairman of the United Way's professional division in Jackson County.

James Keeton of Jackson presented a paper at the American Academy of Pediatrics annual meeting in Chicago.

Steven B. Liverman announces the opening of his office for family practice at Beech Street in Wesson.

James O. Manning, Gene R. Barrett, and Walter R. Shelton of Jackson announce the opening of Manning, Barrett and Shelton clinic, at 1080 River Oaks Office Plaza.

James Martin of UMC presented a paper at a district meeting of the American College of Obstetricians and Gynecologists in Wichita, Kansas.

Francis Morrison of UMC attended meetings of the International Society for Experimental Hematology in Atlanta, the Southwest Oncology Group in Phoenix, where he also presented a paper, and the American Society for Apheresis in Chicago.

William Nicholas of UMC conducted seminars on diabetes in Vicksburg and Union, and participated in "A Day in Medicine" in Meridian.

Edward R. North of Jackson spoke at the Starkville Exchange Club in September.

Shanti Pandey of Fayette has been elected chief of staff at Jefferson County Hospital.

Paul Parker of UMC was speaker during the Mississippi Public Health Association annual meeting in Jackson September 27.

Gerald Robertson, formerly of Laurel, has been named director of Riverside Hospital's diagnostic and evaluation unit.

Ramon H. Rosenkrans has associated with Magee Medical and Surgical Clinic for the practice of general surgery.

Gus A. Rush of Meridian has associated with Rush Medical Group for the practice of orthopedic surgery.

Phil Thompson announces the opening of his office for the practice of family medicine at Highway 35 South in Raleigh.

Guy T. Vise of Jackson was installed this month as president of the Southern Medical Association during the SMA annual scientific assembly in New Orleans.

Stennis Wax of Jackson has relocated his practice of family medicine to South Park Street in Sturgis.

Richard Weddle announces the relocation of his practice of neurology from Tupelo to Jackson, with offices at 1151 North State Street.

Lamar Weems of UMC participated in the executive committee meeting of the National Kidney Foundation in New York and spoke to members of the medical staff at Northeast Mississippi Medical Center in Tupelo during September.

L. W. Willey of Forest was honored at a reception sponsored by S. E. Lackey Memorial Hospital Auxiliary upon his retirement after 30 years of practice.

Winfred Wiser of UMC attended an executive committee meeting of the Society of Gynecologic Surgeons in Chicago and made presentations at the American College of Obstetricians and Gynecologists district meeting in Wichita, Kansas.

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Medico-legal Brief

TV Network Not Liable To Chiropractor for Libel

Television broadcasts on the subject of "cancer quackery" were merely statements of opinion protected by the First Amendment and the state common-law right of fair comment and criticism, a federal trial court in Illinois ruled.

A licensed chiropractor brought an action against a television network for defamation of his character in connection with the series of broadcasts. The broadcasts were based on the work of a reporter and an investigative team who had crossed the country, documenting "an international network of medical quackery."

Among other findings, the reporter described the use of machines, one of which the FDA had declared grossly fraudulent. A federal judge had allegedly declared the machine a quack device because it could not tell a dead patient from a live one. The reporter said that this was one of many worthless devices used by a suburban chiropractor, presumably the one in the present suit, who was pictured on the screen more than once.

The reporter also said that the chiropractor treated patients through "metabolic therapy," using megadoses of vitamins. A patient's insurance company had refused to cover such treatment, and its consultant on chiropractors allegedly said that the chiropractor had overstepped the bounds of his training. Another chiropractor allegedly said that the treatment was unethical, unprofessional, inhuman, and totally worthless. The reporter also said that the chiropractor had sold investigators laetrile in violation of state law.

The chiropractor contended that he was defamed by the broadcasts in that by innuendo, implication, and association his reputation and moral character were damaged. He alleged that the statements were made with malice and intent to do harm and were false. He also complained of the use of "fraudulent" medical reports to gain entry into his office by members of the team posing as patients.

The network moved to dismiss. The court said that, viewed in its entirety, the series of broadcasts amounted to no more than an expression of opinion and commentary based on intensive investigation and stated facts. The court said that the broadcasts were only critical of the chiropractor's acts and did not criticize him personally or as a practitioner within the traditional bounds of the science of chiropractic. Further, the report concerned a matter of public interest. The court entered summary judgment for the network. — *Spelson v. CBS, Inc.*, 581 F.Supp. 1195 (D.C., Ill., March 8, 1984)

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Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

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Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation, see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown*

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

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Consulting Physicians. Board eligible orthopedic and psychiatric consultants needed 25-30 hours per week for evaluation of Social Security disability claims. Positions available immediately. For additional information, please call Deborah Warriner, Medical Staff Coordinator, Disability Determination Services, (601) 923-2153.

PHYSICIANS NEEDED

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact one of the following Medical Relations Officers: Henry Klar (Ext. 2276), Martina Mayfield (Ext. 2227), or Neil McGaughey (Ext. 2249).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 16-20, 1985, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 117th Annual Session, May 15-19, 1985, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 26-29, 1985, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Rebecca Hodges, Box 329, Kilmichael 39747. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Pate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Secy., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Dan Jones, Secy., P.O. Box 2756, Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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Brookhaven, MS 39601

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Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Delta Medical Center
P.O. Box 5247
Greenville, MS 38701

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
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Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
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Corinth, MS 38834

Greenwood Leflore Hospital
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Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

Gulfport Memorial Hospital
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References: **1.** Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Genatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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December 1984

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December 1984, Volume XXV, Number 12

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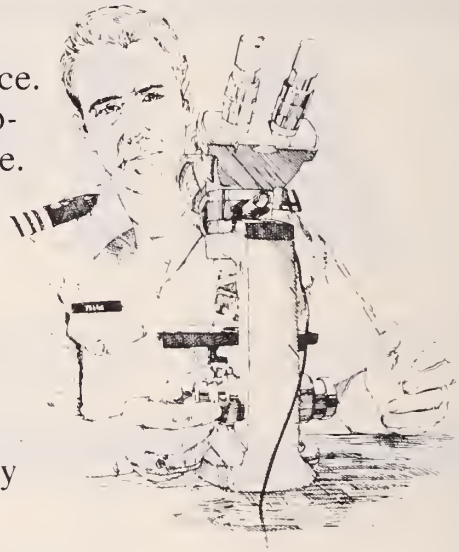

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NEWSLETTER

December 1984

Dear Doctor:

A sigmoidoscopy workshop is offered in conjunction with the UMC's 1985 Family Practice Update, April 24-27. The program is part of a three-year colorectal cancer awareness project sponsored by the American Cancer Society in collaboration with other medical organizations. The project seeks to reduce the nationwide mortality due to the second most common malignancy in the country by increasing the use of the three standard diagnostic techniques for early detection in asymptomatic patients: the digital rectal examination, stood blood test, and proctosigmoidoscopy.

> Colorectal cancer will strike some 1,450 Mississippi residents in 1985. Nationwide it will claim the lives of an estimated 59,400 Americans, 700 from Mississippi. For information about the sigmoidoscopy workshop or the Family Practice Update, contact the Office of Continuing Health Professional Education at UMC.

Blue Cross - Blue Shield of Mississippi has announced plans to market a Preferred Provider Plan (PPO). Currently, providers in the Jackson area are being solicited to participate in the plan. Future efforts will be directed at statewide marketing of the plan.

Physician reimbursement, alternate delivery systems, marketing, and competition in ambulatory care are among current topics that will be discussed at MSMA's 1985 Health Issues Seminar, March 1-2. MSMA members and spouses are encouraged to attend this important session, which will be held at the Downtown Holiday Inn in Jackson. Complete details and registration information will be included in an upcoming edition of the MSMA Report, but members are urged to mark the dates on their calendars now.

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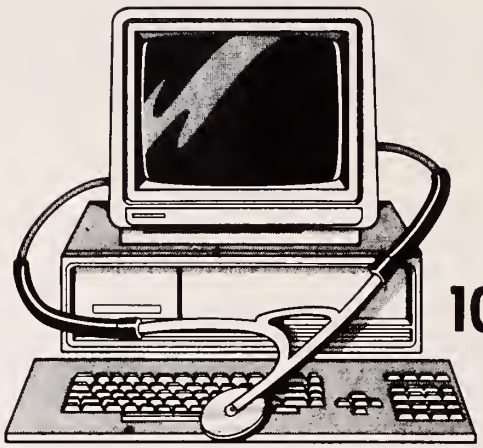

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Incidence less than 1%—Probable Causal Relationship*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown*

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

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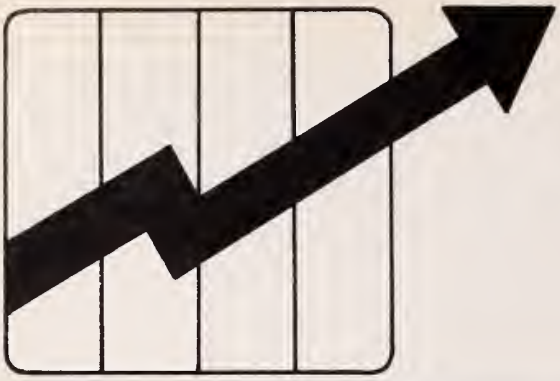

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DATELINE

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Jackson, MS - A reception for physician recruitment will be held January 17, 1985, at the Sheraton Regency Convention Center. Purpose of the reception is to introduce available residents to physicians, mayors, hospitals and other parties interested in recruiting physicians for their communities. Registration fee is $25. For additional information, contact the UMC Department of Family Medicine, 987-4900.

"Mississippi 21" Needs Donations

Jackson, MS - Voluntary contributions are needed to help fund an effort to raise the legal drinking age to 21. "Mississippi 21," an organization of concerned citizens and public and private groups, is attempting - through a program of public information and education - to secure passage of legislation in 1985. Send donations to "Mississippi 21," P.O. Box 5229, Jackson, MS 39216.

Patient Information: New Medicare Law

Jackson, MS - Posters and brochures that help physicians explain to patients why they have chosen not to sign a "participation" agreement under the new Medicare provisions are now available. The materials, produced by the AMA, help explain changes in the Medicare law and reassure patients that their physicians desire to continue providing quality medical care. Order from MSMA. Please allow two weeks for delivery.

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Arlington, VA - President Reagan has proclaimed January 1985 as National Volunteer Blood Donor Month. During the month tribute will be paid to the "quiet heros" who provide the blood needed for the entire population. Over 15,000 donors are needed daily to meet the everyday need. Volunteers contribute 98% of blood and components transfused. Approximately 40% of people are eligible to donate; yet only 10% contribute.

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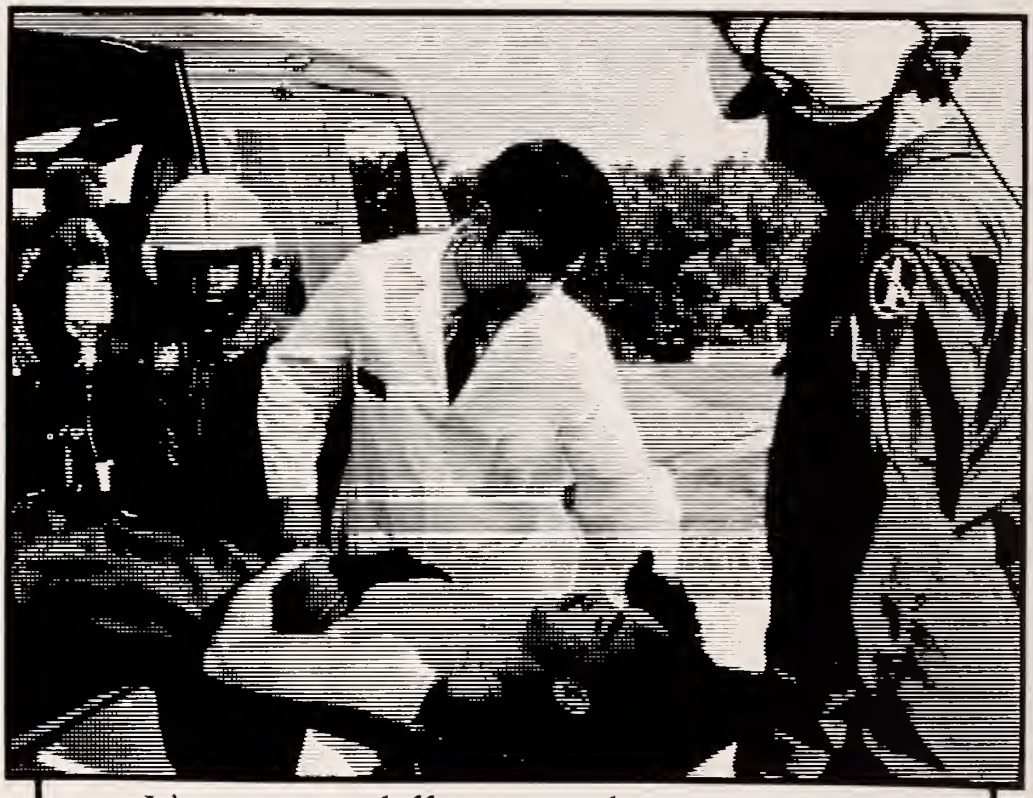

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December 1984, Volume XXV, Number 12

ORIGINAL PAPERS

Treatment of 300 Consecutive Morbid Obesity Patients With Gastric Bypass

CHARLES E. FARMER, M.D. and JACK B. CAMPBELL, M.D.
Jackson, Mississippi

Patients with morbid obesity have a decreased life expectancy, have difficulty obtaining steady employment, and are often socially isolated. The authors maintain that attention given to the problem should be no less than that directed to other self-inflicted diseases such as cirrhosis of the liver, carcinoma of the lung and certain types of atherosclerotic diseases. They describe treatment of 300 consecutive patients with gastric bypass.

OBESITY IS AN EPIDEMIC problem that does not spare any age, socioeconomic class or ethnic group.[1, 2] Although the exact prevalence of obesity is difficult to determine, it has been estimated that 30 to 40 million Americans are obese.[2]

This paper, however, encompasses only those patients who are morbidly obese or who are 100 pounds over ideal weight or double their ideal weight as based on the standard life insurance tables. Whether obesity is considered a symptom or a disease, there are few questions that evoke more controversy.[9]

Patients with morbid obesity have a decreased life expectancy, have difficulty obtaining steady employment and are often socially isolated.[8] Attention given to the problem of obesity should be no less than that directed to other self-inflicted diseases such as cirrhosis of the liver, carcinoma of the lung and certain types of atherosclerotic diseases.

Medical and psychiatric weight reduction programs have a discouragingly low success rate in that no more than 13% of the patients will lose as much as 40 pounds after entering treatment.[3] Although conservative therapy is essential, it usually will be met with failure in most patients who are morbidly obese.

The purpose of this paper is to report our experience and knowledge in the treatment of patients with morbid obesity by the use of the gastric bypass. We first began performing the gastric bypass in 1979 and have continued to utilize this procedure because of its low complication rate and proven effectiveness. Four hundred and forty-five patients have been operated upon for morbid obesity. However, this report confines itself to the first 300 cases.

Candidates for the gastric bypass should be 100 pounds over their ideal weight or two times their normal weight. Each patient must be emotionally well motivated. On the initial office visit, the technical procedure, the potential complications and the expected benefits of the surgery are explained. Routine psychiatric evaluation has not proven necessary or cost effective, although occasional patients have been under psychiatric care for their obesity and some patients are requested to consult a

Drs. Farmer and Campbell are engaged in the private practice of surgery in Jackson, MS.

psychiatrist prior to making the final decision to undergo gastric bypass. The positive psycho-social changes that have been observed following weight loss suggest that the anxiety, depression and low self esteem noted in the morbidly obese patients may be the result of their obesity rather than the cause of it.[4]

It has been our experience and the experience of other bariatric surgeons that patients over the age of 50 do not lose as much weight and have more post-operative complications than younger patients.[5] For this reason, we have only operated upon a few select patients in the 50-and-over range. However, nationwide, there is a tendency to operate upon older patients if they have medical complications related to their obesity.

There are a number of different operations that are classified under the general heading of gastric stapling. These include gastroplasty that has been popularized by Gomez and vertical banded gastroplasty currently used by Mason. Each of the different procedures have certain technical and surgical characteristics that make them unique. The particular procedure we employ is the classic bypass utilizing proximal trans-gastric stapling and a Roux-en-y pouch-enterostomy. When performing gastric bypass, proper attention to technical details is essential. It is necessary to develop a 50cc pouch of measured volume and a gastroenterostomy no larger than 1.5cm in diameter.[10] Experience has taught that variation from these sizes will frequently result in failure to lose the desired weight.

Sixty-seven percent of our patients have medical complications (see Table 1) including diabetes, hypertensive cardiovascular disease, arthritis, Pickwickian syndrome, pulmonary insufficiency, gallstones, abnormal menstrual cycles including amenorrhea and infertility. If these medical problems are found, they are extensively evaluated, usually at the time the patient is admitted to the hospital for surgery. Some metabolic evaluations have been routinely performed but have not proven to be the cause of the obesity in any cases thus far. Although every patient did not have medical complications, the most dramatic response was seen in those patients who had been treated for hypertension and diabetes. Cholesterol and triglyceride factors are determined at intervals and were markedly lower after a period of weight reduction. Most of the patients with sexual problems overcame this complication with weight reduction.

Weight loss varied from 40 to 286 pounds. The surgery is considered technically successful if the patient loses at least one-third of his preoperative weight. Eighty-nine percent of the patients have achieved this goal. The operation is designed to control the amount of food that the patient consumes. Unfortunately, it does not have any effect on the *type* of foods that are eaten. We have had no patient lose an excessive amount of weight. In fact, most patients will stop losing shortly before reaching their desired goal. With a few patients, there has been a tendency to gain after the initial weight loss has stabilized. This is usually the result of a high carbohydrate diet and can be controlled by more protein consumption.

TABLE 1
MEDICAL COMPLICATIONS

Diabetes
Hypertensive cardiovascular disease
Arthritis
Pickwickian syndrome
Pulmonary insufficiency
Gallstones
Abnormal menstrual cycles
Amenorrhea
Infertility
Sexual disturbances

TABLE 2
OPERATIVE COMPLICATIONS

Perforation of gastroenterostomy or pouch — 6
Stenosis of the gastroenterostomy — 8
Marginal ulcer — 4
Pulmonary emboli — 3
Pulmonary insufficiency — 1
CVA — 1
Empyema — 1
Intestinal obstruction — 2; Late — 9
Major wound infections — 3
Incisional hernias — 12

Fourteen patients have required a revision of the operation for failure to lose adequate weight because of pouch dilatation and/or gastroenterostomy dilatation. Eleven of these patients experienced a successful result. Two patients failed to improve, and one patient had the bypass reversed because of her inability to tolerate the reduced food consumption.

The major postoperative complications are listed in Table 2 and include perforation of the gastroenterostomy which occurred in six patients, three of whom required surgical closure of the perforation, while the remaining three were managed with nasogastric suction, intravenous fluids and antibiotics. Stenosis of the gastroenterostomy occurred in eight

TABLE 3
MORTALITY CAUSES

Pulmonary embolus — third post-operative day
CVA — eighth post-operative day
Pulmonary insufficiency — third post-operative day

patients, all of whom required surgery for dilatation. Attempted dilatation through the gastroscope has been unsuccessful, but this problem is still approached by initially attempting gastroscopic dilatation. Four patients had postoperative marginal ulcers with pain or bleeding, and two of these required surgical intervention. One of the two had the bypass reversed at a later date due to recurrent infection. There were three pulmonary emboli and one cerebrovascular accident (CVA). One empyema required drainage. Two patients developed an early intestinal obstruction and required reoperation. Nine patients required surgery for small bowel obstruction occurring from two months to four years following their initial gastric bypass. There were three major wound infections. Twelve incisional hernias required repair. Thirty-seven patients have required cholecystectomy subsequent to their gastric bypass.

In the first 300 patients, there were three deaths (see Table 3) for an overall mortality rate of 1%. The last death was patient 144. In our total experience to date, there have been no deaths in the last 293 gastric bypass patients.

Summary

The gastric bypass has been proven both on a national basis and in our hands to be the most effective method for the morbidly obese patient to achieve sufficient weight loss to avoid the complications of their disease. This procedure has gained in popularity nationwide and is being performed on increasingly greater numbers of patients each year.

We believe the gastric bypass to be the procedure of choice in those patients who meet the criteria and are otherwise acceptable surgical risks. ★★★

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MSMA CALENDAR

March 1-2, 1985	Health Issues Seminar	Jackson, MS
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External Beam Irradiation for Prostate Cancer: The MBMC Experience and a Literature Review

MORRIS T. REAGAN, M.D., R. ARNOLD SMITH, M.D., and ROY E. STEADHAM, M.S.
Jackson, Mississippi

Between 1976 and 1982, 167 patients with localized prostate cancer were treated with external beam irradiation at Mississippi Baptist Medical Center. The patients were treated with 6400 to 6850 rads administered over eight to nine weeks. The actuarial 5-year survivals for patients with stage A, B and C disease were 100%, 91% and 80% respectively. There were no serious complications. The authors compare their methods and results with those published in seven recent series.

ADENOCARCINOMA OF THE PROSTATE was once considered "radioresistant." Thus the appearance of numerous reports during the last 20 years that adequately applied external supervoltage irradiation results in long-term tumor control in most patients with disease confined to the pelvis, even those surgically incurable, constitutes a landmark in oncology. We present an analysis of our experience at Mississippi Baptist Medical Center (MBMC) with 167 patients with prostate adenocarcinoma who received potentially curative radiotherapy between 1976 and 1982, and compare our results with those reported in recent large series.

Materials and Methods

From 1976 to 1982, inclusive, 167 patients completed a course of radiotherapy administered with curative intent for clinical stage A, B or C adenocarcinoma of the prostate. The diagnosis was established in every case by histologic examination of material obtained from needle biopsy or transurethral resection of the prostate. Evaluation always included a history, physical examination, chest x-ray, intravenous urogram, bone scan, acid and alkaline phosphatase, and complete blood count. By these means patients were staged clinically as summarized in Table 1.

Treatment was administered with a cobalt-60 teletherapy unit until the end of 1980, after which a 15 million-volt linear accelerator was used. All patients were treated five times per week. The daily dose was 180 rad, except in some patients with such risk factors as hypertension, diabetes mellitus, previous rectal surgery, or extreme old age, when a daily dose of 170 rad was sometimes used. The prostate gland and pelvic lymph nodes usually were irradiated in the initial part of the therapy (see Figure 1). When cobalt was used, this volume was encompassed by four fields (anteroposterior, posteroanterior, and left and right laterals), but with only two fields (anteroposterior and posteroanterior) when the linear accelerator was employed. When a mid-plane dose of 4200 to 4500 rad was reached, the patient received a one-week break, following which a reduced volume including only the prostate and immediately surrounding tissues were irradiated with a rotational technique to a dose of 6400 to 6850 rad, depending on the size of the tumor (see Figure 2).

In early November 1983, the status of each patient was determined by a telephone call to the patient or his family. Only eight patients (three with stage B and five with stage C disease) could not be traced. The information thus obtained was used to construct the actuarial survival curve shown in Figure 3.

Results and Discussion

Almost all patients were able to maintain a moder-

From the Department of Radiation Therapy, Mississippi Baptist Medical Center, Jackson, MS.
Presented in part to the Mississippi Urological Society, November 13, 1983.

TABLE I
DISTRIBUTION OF PATIENTS BY STAGE

Stage	*Clinical Extent of Disease*	*Number of Patients*
A	Unsuspected cancer found in TURP specimen.	15
B	Palpable cancer confined within prostatic capsule.	63
C	Extension of cancer beyond prostatic capsule, but not beyond pelvis and not involving bone.	89

ate activity level during the treatment. All patients developed erythema in skin folds encompassed by the beam, which progressed to moist desquamation in some. Approximately 75% to 90% had diarrhea, and dysuria was common. These usually mild acute effects of irradiation were controlled with simple means such as sitz baths and diphenoxylate, and mostly subsided within four to six weeks after the therapy was over.

In Table 2 our experience with 167 patients is compared with that in seven other series where patients were treated with curative intent with external beam irradiation. This table summarizes the survival rates by stage and incidence of serious complications (defined as those causing death or necessitating surgical intervention) for 1,833 patients. The survival rates shown in Table 2 are 5-year actuarial survivals for all institutions except M. D. Anderson, which reported its results as the absolute survival at the time of analysis (mean follow-up period, 6.75 years). The statistics from Washington University and Stanford represent disease-free survival rates, but the survival rates from the other institutions were reported without regard to disease status. There appears to be no doubt that external beam irradiation can dramatically improve survival expectancy, since only 22% of untreated patients with stage C disease survive for three years.[8] The different methods of reporting used by the institutions in Table 2 and the variation in length of follow-up make a meaningful comparison of survival rates difficult. However, it appears at this point in time that the survival rates in our patients at least equal those achieved in the other series in Table 2. One of us (RAS) has systematically administered the antioxidants selenium and vitamins E and C to patients undergoing radiotherapy for prostate cancer with the belief that those agents may enhance survival. Since the other physician (MTR) has been contributing patients to this series only since July 1980, it is still too early to assess the effects of antioxidants.

No patient in our series had a serious complication. Since the referring physician assumes primary responsibility for the follow-up of our patients, we cannot be certain about the incidence of less serious late effects of irradiation, but we know of one case each of persistent diarrhea, rectal ulcer, late radiation cystitis, and persistent proctitis. These all resolved with conservative treatment. A comparison of our dose-fractionation pattern with the others

Figure 1. Portal encompassing prostate and pelvic lymph nodes.

Figure 2. Portal for additional irradiation of prostate.

TABLE 2

RESULTS OF RADIOTHERAPY FOR LOCALIZED PROSTATE CANCER AT EIGHT INSTITUTIONS

Institution	*Serious Complication [Percent]*	*Study Period (Minimum follow-up) [Years]*	*Usual Dose [Rad]* *Per day*	*Total* *Pelvis*	*Prostate*	*No. of Patients (Percent Survival)* *Stage* *A*	*B*	*C*
M. D. Anderson[1]	8.2	8 (4)	200	None	6000-7000	0	5 (100)	165 (55)
Univ. of Cincinnati[2]	1.0	6 (2)	220	None	6200-7500	15 (90)	60 (70)	41 (40)
Washington Univ.[3]	3.6	10 (2)	180	5000	6000-7000	0	42 (80)	153 (52)
Columbia Presbyterian[4]	1.4	12 (less than 1)	200	None or 4800	5000-7200	13 (88)	21 (86)	112 (58)
Virginia Mason[5]	0.4	10 (2)	180	5000	6500-7000	10 (70)	36 (59)	221 (58)
Stanford Univ.[6]	0.2	19 (less than 1)	200	None	7000-7600	0	230 (77)	200 (44)
Univ. of Alberta[7]	?	8 (2)	200	None or 3000	6000	342	(Stages A, B, and C) (78)	
Present series	0	6 (0.83)	180	4200	6400-6850	15 (100)	63 (91)	89 (80)

summarized in Table 2 shows that in our series the maximum dose was slightly lower, and the time over which it was administered slightly longer than in the others. It is well established that the effect of a given dose of radiations on normal tissues is diminished when the time over which the dose is administered is increased. Thus the high survivals, generally mild acute radiation reactions, and absence of serious complications observed in our patients suggest that the usually slow growth rate of prostate cancers makes feasible treatment with a protracted fractionation schedule which minimizes side effects and risks without adversely affecting survival.

Serious complications of radical external irradiation for prostate cancer are usually due to rectal injury. The combined incidence of these for all the series of Table 2 in which they were reported is 1.7%. Of the series in the table, only M. D. Anderson reported a complication rate sharply higher than this combined value. In his analysis of the M. D. Anderson experience, Hussey concluded that complication risk increases sharply as the tumor dose rises from 6500 to 7000 rad. Yet factors other than dose must be very important, since only 0.2% of Stanford patients had major complications, even though all 430 patients in their series received at least 7000 rad. Portal arrangement may be an important factor. At M. D. Anderson, anterior and posterior portals fully encompassing the rectum were used throughout the treatment, but 360-degree rotational or bilateral arc portals were employed at Stanford.

Interstitial prostatic irradiation with permanent implants of materials like I-125 or temporary implants such as iridium-192 has been explored extensively, but we know of no evidence that it controls disease more effectively than external beam therapy, and several groups have reported serious complications in more than ten percent of patients treated with implants.[9, 10] Interstitial therapy also necessitates hospitalization and exposes personnel to potentially hazardous radiations. For these reasons we believe that judiciously applied external beam irradiation is the treatment of choice for most patients with cancer of the prostate confined to the pelvis. ★★★

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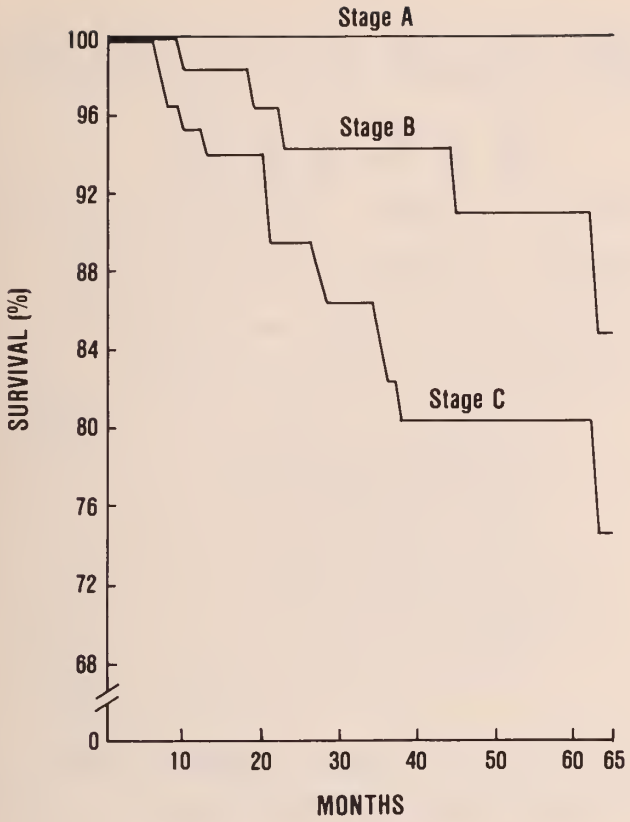

Figure 3. Actuarial survivals by stage.

Acknowledgement

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Malignant Neck Masses in Adults

C. RON CANNON, M.D.
Jackson, Mississippi

ASYMMETRIC ENLARGEMENT of a cervical node or nodes in the adult should arouse suspicions of a cancerous growth. These usually represent metastasis from a primary lesion of the head and neck, most likely from the upper food and air passages.

It has been estimated that a neck mass is the initial presentation of a head and neck malignancy approximately 10% of the time. Concomitant complaints of aerodigestive tract dysfunction such as hoarseness or dysphagia further heighten the suspicion of a neck mass being malignant.

The purpose of this paper is to discuss the management of the adult patient with a malignant neck mass.

Pre-disposing Factors

Of prime importance in aerodigestive tract cancers is a history of heavy tobacco or ethanol use. Both have been implicated due to their chronic irritant effects. In pipe and cigar smokers the irritation is localized to the oral cavity, while in cigarette smokers the whole upper aerodigestive tract is at risk to develop cancer. Alcohol abuse causes hepatic injury which can decrease the liver's detoxification capacity and may enhance carcinogenesis. Ethanol also serves as a cofactor in the production of known carcinogens.

There are other factors which play a role in development of a cancer metastatic to the neck. Patients with actinic damage may develop a skin cancer of the face or scalp. Cervical metastasis from such a skin lesion may occur months to years later. The carcinogenic effects of radiotherapy are widely recognized and prior irradiation for such entities as thymus enlargement, acne, and adenoid hypertrophy is significant. The patient's social or work history may play an important role, for example — in the furniture industry, wood workers have a much higher incidence of maxillary sinus cancer than does the general public.

Dr. Cannon is engaged in the private practice of otolaryngology and head and neck surgery in Jackson, MS.

Physical Examination

In this age of sophisticated laboratory and diagnostic testing, the cervical neck mass remains an area in which astute physical examination remains of utmost importance.

The neck mass must be carefully examined and notes made of the size, location, consistency, and presence or absence of tenderness of the mass. All cutaneous and mucosal surfaces of the head and neck, including the scalp, ears, nose, lips, oral cavity, nasopharynx, hypopharynx, and larynx are thoroughly examined. The parotid, submandibular, and thyroid glands should be carefully palpated. Bimanual palpation can further delineate any mass or lesions in these areas.

The clinician should utilize inspection of the oral cavity and should be proficient in mirror examination of the nasopharynx, hypopharynx, and larynx.

Laboratory Studies

Laboratory tests are occasionally helpful in making a diagnosis in a patient with a neck mass, but are not routinely useful in eliciting vital information regarding the etiology of a neck mass.

The best screening tests are the chest X-ray to detect pulmonary pathology such as a bronchogenic carcinoma and a complete blood count to diagnose blood dyscrasias. Other tests which may be helpful are outlined in Table I. These studies are selectively utilized if a patient has complaints referable to a specific area. For example — a parotid sialogram might supply useful information regarding a parotid mass, a barium swallow in a patient with dysphagia, or a thyroid scan to evaluate a thyroid mass.

The CT scan is a new and versatile diagnostic tool. Indications for its use in evaluation of neck masses are still being discovered. In patients with known metastatic disease to the neck the CT scan can supply useful information about the resectability of these masses. It is useful in documenting the baseline extent of the disease and for comparison after treatment has been effected.

TABLE I
LABORATORY TESTS TO EVALUATE NECK MASSES

CBC	Sialogram
CXR	Tomograms
Sinus Films	Thyroid Scan
Barium Swallow	CT Scan
Laryngogram	

TABLE II
ETIOLOGY OF THE METASTATIC NECK MASS

85%	Primary Head and Neck Neoplasm
9%	"Distant" primary tumor
5%	Occult primary tumor
1%	Systemic or Constitutional Neoplasm

Malignant Masses

It is recognized that any asymmetric neck mass in an adult most likely represents metastasis from a primary cancer of the upper aerodigestive tract.[1, 2]

Eighty-five percent of all malignant neck masses are from a primary lesion of the head and neck.[3, 4] Other possibilities are a distant primary tumor, 9%; an occult or hidden primary lesion, 5%; or a constitutional neoplasm, 1% (see Table II).

Approximately 40% of all metastatic neck masses arise from the oropharynx, 40% from the laryngopharynx, 10% from the thyroid gland and the remaining 10% from miscellaneous sites about the head and neck. About 90% are squamous cell carcinomas.

Distant primary lesions arise most commonly from the lungs. Occasionally lesions from the GI tract, breasts, and prostate gland will metastasize to the neck. These metastatic nodes are usually found in the supraclavicular region.

Five percent of all malignant neck masses arise from an "occult" or hidden primary lesion. In these patients the primary tumor is not obvious and may be found only after a careful search of the head and neck and occasionally other areas. In a review of a large series of patients the primary lesion was found in only 29%.[5-11] Several percent of these were from the head and neck and 30% from sites below the clavicle. Sites of predilection for these occult tumors are the nasopharynx, thyroid, tonsil, tongue base, and pyriform sinus. The pyriform sinus is a blind recess of mucosa located within the confines of the thyroid cartilage. A small or microscopic foci of tumor in one of these areas can lead to large cervical metastasis.

Constitutional neoplasms such as Hodgkin's disease, lymphosarcoma, or leukemia may present initially as a cervical mass. If the patient has constitutional symptoms and lymphadenopathy in other sites suspicion of this type of pathology is heightened.

Histologic Diagnosis

If a patient is thought to have a malignant neck mass, a histologic diagnosis should be obtained to formulate a proper treatment plan.

The most appropriate method to arrive at the proper diagnosis is to biopsy the primary lesion. A careful head and neck examination will usually reveal the primary lesion, which can then be biopsied. For example, a patient with hoarseness and a lesion within the larynx on indirect laryngoscopy should undergo biopsy of the laryngeal lesion to obtain a histologic diagnosis.

In some cases the head and neck examination fails to show a primary lesion. In these instances the metastatic disease in the neck may have to be sampled to obtain a diagnosis. Fine needle aspiration with a 21 or 22 gauge needle is becoming increasingly relied on to obtain a histologic diagnosis. In this procedure a small gauge needle is inserted into the mass and moved to and fro while holding a slight vacuum on the syringe. The aspirated material is then spread on a slide and fixed with a fixative solution. This procedure is minimally invasive, of minor discomfort to the patient, and is often reliable in making the diagnosis of squamous cell carcinoma and thyroid tumors.[12, 13] It is less reliable in making the diagnosis of salivary gland tumors. In other cases an open biopsy of the mass may have to be carried out to obtain a definitive diagnosis. In this situation the incision over the mass should be carefully

Figure 1. Metastatic squamous cell carcinoma invading neck following open biopsy

planned, and if metastatic squamous cell carcinoma found, the surgeon should be prepared to perform a radical neck dissection.

Open biopsy of a neck mass before complete head and neck examination is contraindicated (see Figure 1). McGuirt and McCabe have studied the effects of cervical node biopsy before careful head and neck examination and identification of the primary lesion.[2] They found that the complications of wound necrosis, local recurrence, and most importantly distant metastasis were significantly increased in those patients who had an inappropriate biopsy of the neck. For these reasons a biopsy of the neck should not be attempted until a careful and complete head and neck examination, under general anesthesia if necessary, is carried out.

Summary

The adult with a neck mass often presents a diagnostic dilemma. Neoplastic disease should be considered and the following management principles kept in mind:

(1) A high index of suspicion that a cervical neck mass could be malignant.
(2) Always perform a careful head and neck examination including all the cutaneous and mucosal surfaces.
(3) A neck mass should be considered to be metastatic from a primary head and neck lesion until proven otherwise.
(4) Never biopsy a neck mass until a careful head and neck examination is done. ★★★

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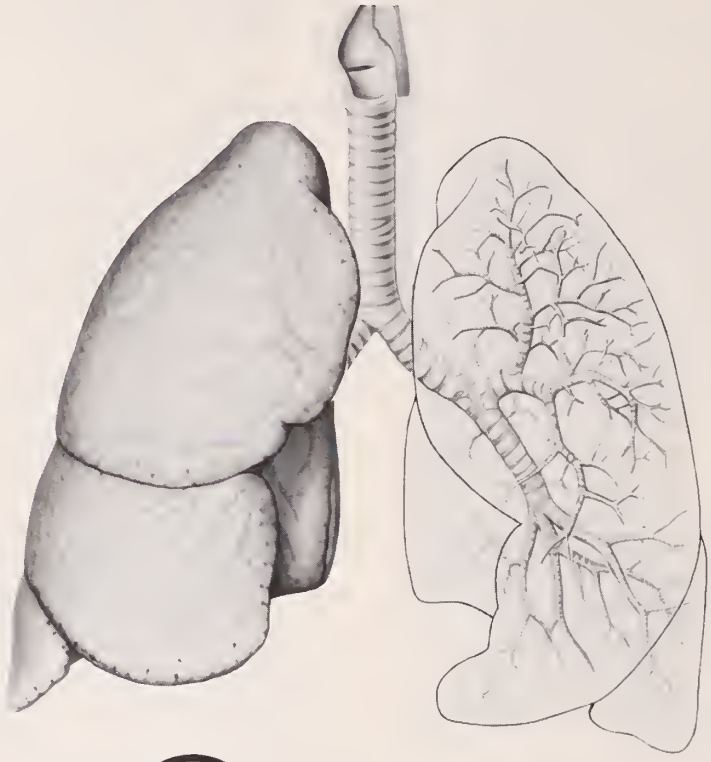

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Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

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Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbiliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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Obstetrics and Gynecology Grand Rounds: Clinical Case Management VII

Management of Menstrual Disorders in Adolescence

G. RODNEY MEEKS, M.D., Moderator
Jackson, Mississippi

Dr. Meeks: L.W. is a 16-year-old gravida 0 black woman. She had been in her usual state of good health until approximately four months before this admission, at which time she developed amenorrhea with no other symptoms. She presented with very heavy vaginal bleeding which could not be controlled with menstrual napkins, which caused her to soil her underclothing and clothing and which was associated with approximately fist-sized clots.

The patient weighed 115 pounds and stood 66 inches. Her blood pressure was 100/70 mmHg. Her pulse was 110 per minute and her respiratory rate was 20 per minute. She was somewhat pale and had pale conjunctiva. She had normal female pubic hair distribution with old and fresh clots on the perineum. The vagina was pink and rugated with a moderate amount of blood. No vaginal lesions were identified and no evidence of trauma was seen. The cervix was free of lesions and the os was closed. A moderate amount of thin cervical mucus was present which was admixed with blood. The uterus was anterior, mobile, firm, normal size and shape, and slightly tender. No adnexal masses were palpated. The rectal exam confirmed the pelvic and there were no intrinsic masses.

What diagnoses should be included in a patient such as this?

Dr. Meek: In a general way one should consider all the causes of abnormal uterine bleeding. One should start at the level of the hypothalamus and include the pituitary, the ovary and the uterus as possible causes. Certainly adolescents are not immune to benign and malignant uterine neoplasia, blood dyscrasia, genital trauma or complications of pregnancy. Of course, I would be concerned about pregnancy because this is the most frequent organic cause of abnormal bleeding in this age group.

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS.

Panelists: Edwin "Dick" Meek, M.D. of Greenwood and Hilda McGee, M.D., Hattiesburg.

Dr. McGee: Some additional history would help in separating out the cause of the bleeding. For instance, did she have any subjective symptoms of pregnancy such as nausea, vomiting, breast tenderness or urinary frequency? Also has she had any other bleeding or any other endocrine abnormalities?

Dr. Meek: I would also like to know if she had any history of pelvic infections or endometritis. Does she have a family history of bleeding problems, for instance her mother or any of her sisters who may have had excessive menstrual cycles? Is she sexually active? You can not always believe this aspect of the history but it would be an important start anyway.

Dr. Meeks: The patient had menarche at age 13 and her menses were monthly although slightly irregular. Her normal period lasted four days and on the heaviest day of flow she required four partially soaked pads. She gave no history of easy bruising, bleeding from the gums or excessive bleeding with minor injuries. There was no evidence of other endocrine abnormalities and in particular no history of thyroid disease or galactorrhea. The remainder of her general physical examination was unremarkable. She had been sexually active without benefit of contraception. Would any laboratory help at this point?

Dr. Meek: I would order a pregnancy test, a complete blood count and a clotting profile.

Dr. Meeks: Her hematocrit was 21% and her platelet count was 250,000. A prothrombin time (PT) and partial thromboplastin time (PTT) were

both normal. A urine pregnancy test was negative. Is there any place for a serum test in situations like this?

Dr. McGee: Certainly if viable trophoblastic cells remain, the serum test will be positive. In addition, it becomes positive earlier than most urine tests. The accuracy is almost 100%.

Dr. Meeks: A serum pregnancy test was also obtained and was negative.

Dr. Meek: Then pregnancy can be eliminated as a cause of the bleeding. In addition, with a normal exam lesions such as fibroids can be eliminated and with normal clotting studies and platelets, blood dyscrasias and clotting abnormalities can be eliminated as a source of the uterine bleeding. There remains a small chance that the patient could have a polyp, endometrial hyperplasia, or cancer. However these are exceedingly rare in this age group. Most likely this patient has some sort of hormonal problem resulting in a disturbance of the usually finely synchronized menstrual cycle. This is so called dysfunctional uterine bleeding which has no organic cause, ie, the bleeding is not secondary to neoplasia, inflammation or pregnancy. Most often this results from anovulatory bleeding or what some may call unopposed estrogen. The diagnosis of dysfunctional bleeding is really one of exclusion. However, most other abnormalities have been excluded.

Dr. Meeks: What would be your next step in management?

Dr. Meek: I believe the first thing that must be done is to correct this patient's anemia. Next one must decide whether additional work-up is necessary to make a diagnosis or whether one should go straight to some therapy. Some would recommend a dilation and curettage (D&C) for anyone who is having irregular bleeding. The D&C would provide a diagnosis and very often is therapeutic. Additionally some might recommend laparoscopy and/or hysteroscopy.

Dr. McGee: I would be more conservative. In a young woman such as this who has not previously been pregnant, who has a somewhat immature uterus based on her age (even though she has been sexually active) there is a significant risk of uterine injury at the time of D&C. In addition, the risk of infection and of intrauterine synechiae are always present. If possible I would avoid blood transfusion because of the risk. An alternative would be to utilize hormonal therapy. I would give her large doses of intravenous (IV) estrogens. One can give 25 mg conjugated estrogen IV every eight hours until the bleeding subsides. Few risks are associated with giving IV estrogens, but nausea is likely. Certainly one can utilize IV estrogens and see if bleeding stops. If the bleeding fails to stop, then one may proceed with the D&C. Should the D&C be necessary, I would transfuse her before the procedure.

Dr. Meeks: Why give estrogen to control the bleeding?

Dr. McGee: With a large amount of bleeding much of the endometrium is denuded and often only the basalis remains. The basalis is not particularly responsive to progesterone no matter what dosage is given. The basalis does seem, however, to have estrogen receptors to allow proliferation to occur. There do not appear to be significant numbers of progesterone receptors and the basalis can not respond to progestational agents alone.

Dr. Meeks: If the patient were bleeding less heavily would you opt for other therapy?

Dr. Meek: In a woman who was having irregular bleeding, but not to the extent of this patient, I would consider progestins. Certainly from the examination it appears that she is estrogenized, and I would agree with our earlier assessment that she is anovulatory.

Dr. McGee: I agree in someone who is bleeding less heavily, I would consider using progestin. Also someone this age who has attained an adult height, I would not hesitate to start oral contraceptive pills. Because she has lost so much blood I would begin iron therapy so that she could replenish the lost red cells.

Dr. Meeks: This patient initially responded to conjugated estrogen (Premarin). She received 25 mg IV every 12 hours for a total of four doses. The patient had diminution of the vaginal bleeding and cessation following two doses. After the IV medication was discontinued she was started on diethylstilbesterol (DES) 25 mg daily. She was continued on hormonal therapy for approximately one month. At that time she was seen and her hemocrit was 33%. Once the bleeding stopped, what would you do next?

Dr. Meek: Since she has had time to rebuild her blood count I would now add progestational therapy. I would give medroxyprogesterone (Provera) 10 mgs daily for five days and allow her to withdraw. If she fails to withdraw for a menstrual cycle during the following month at the anticipated time, I would then repeat the medroxyprogesterone the second month.

Dr. McGee: I would start her on oral contraceptive pills and continue them for at least three months in a cyclic fashion.

Dr. Meeks: Had she not responded to the hormonal therapy what approach would then be necessary?

Dr. McGee: I think a D&C is then necessary.

Dr. Meek: I would certainly concur.

Dr. Meeks: In summary, adolescents are at risk for dysfunctional uterine bleeding. This abnormal bleeding has no organic cause such as benign or malignant neoplasia, blood dyscrasia, trauma or pregnancy. With no abnormality on physical exam or the laboratory evaluation, a course of hormonal therapy is recommended in most circumstances. With very heavy vaginal bleeding, intravenous estrogen would be appropriate. The estrogen seems to produce proliferation of a denuded endometrium and spasm of the spiral uterine arteries. If the bleeding is less severe, a course of a progestational agent or oral contraceptive pills might be appropriate. Once the patient has ceased bleeding she should be cycled for several months, either with progestational therapy or oral contraceptive pills. Also, iron replacement should be started to help correct the anemia. If she fails to respond to high doses of intravenous estrogen or the progestational therapy, she is then a candidate for D&C. Certainly, D&C is a matter of concern in a young woman whose uterus and cervix may be immature and more susceptible to injury. They may also be at greater risk for synechiae formation or endometritis. One must finally reemphasize that this management is for the *adolescent* with abnormal menstrual bleeding.

I would like to thank our panelists for coming today. They take a large amount of time away from their practices to provide perspective in the management of difficult situations. ★★★

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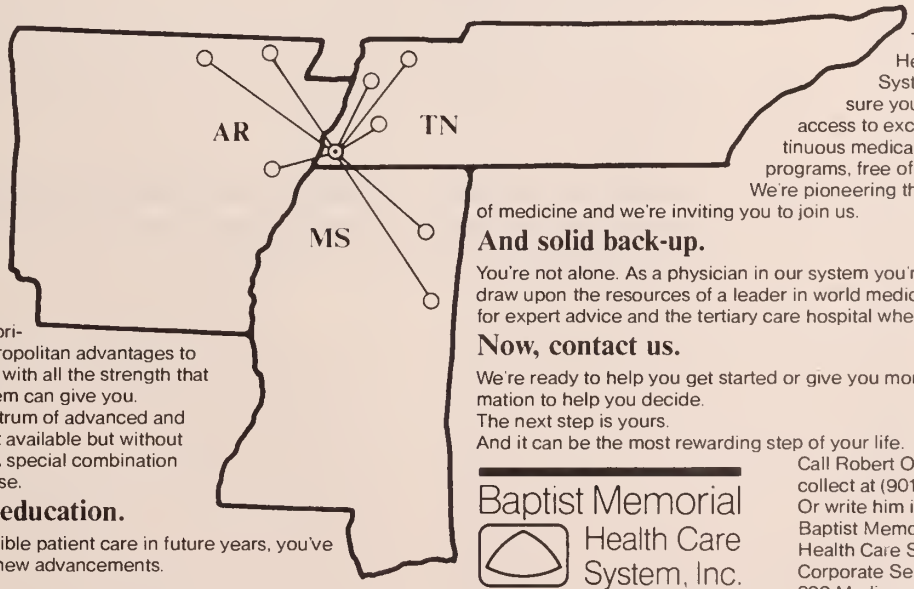

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The President Speaking

Mississippi Industries Are Taking Measures to Control Health Care Costs

Ellis M. Moffitt, M.D.
Jackson, Mississippi

On September 20, 1984, I had the pleasure of addressing and attending the Mississippi Manufacturers Association seminar, "Managing Health Care Costs in Mississippi."

This was an excellent program, well-attended by 70 different manufacturers from all sections of the state with a common thought that health care costs were too high. I enjoyed listening to different participants explain their own means of dealing with cost containment measures within their own confines — all the way from PPO formation to moaning and groaning.

Beginning on page 338 is a list of some of the measures instituted by different companies.

From this list of cost containment measures, you can see that a number of these are what we have been advocating for some time. Look these over. Then see what you can do to help contain health care costs.

This would be an excellent time for a group of you to meet with chief executive officers or health benefits officers for the industries in your area and offer your help in controlling health care costs. This approach is working in several areas.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXV, Number 12
DECEMBER 1984

Mississippi Hospitals — Paradox of Frugality

U. S. News and World Report, October 8, 1984, gives a tabulation of hospital costs state by state. The highest cost was in California at $276/day. The lowest cost was in Mississippi, where our average daily cost is only $108/day. The U. S. average is $203/day. This information was no big surprise, but the implications deserve comment.

Undoubtedly, we have lower labor costs in Mississippi, and some of the other ingredients of the cost of doing business are cheaper here than in many other states. However, I doubt that these economies fully explain a difference between us and them which is almost 100%. These figures indicate to me that hospitals in Mississippi practice a more Spartan use of resources and more efficient management. If past is prologue, in federal cost containment efforts this frugality paradoxically spells trouble for our hospitals.

Consider the "profile" method of computing physician reimbursement. Physicians who had the foresight to charge exhorbitant fees have been rewarded for their avarice. Those who were restrained in their charges have been penalized and are now locked into a disadvantaged position in the Medicare program by the freeze. Hospitals can look for the same kind of treatment in all probability.

In negotiating the PRO Contract for the Mississippi Foundation for Medical Care, we were reminded repeatedly that the admission rate in Mississippi per 1000 Medicare eligibles is 10% higher than the national average. Not once did anyone on the other side of the table mention that our hospital average daily cost is about one half the national average. The contract which we signed commits the Foundation to an effort to reduce admissions. We have substantial evidence, gained in previous PSRO utilization review, that this objective can be met without significant compromise in quality of patient care. However, the effort to reduce hospital admissions will place considerable strain on hospital budgets. The financial stress will be especially severe if our hospitals are required to hold the line on their average daily cost. It seems to me that it is important for physicians to be aware of this problem and to be prepared to help gain equitable reimbursement for our hospitals, even as we try, by utilization review, to eliminate waste and abuse.

W. Lamar Weems, M.D.
Jackson, MS

Medico-legal Brief

Grounds for License Revocation Include Failure to Inform About Breast Disease Treatment Alternatives

The Kansas legislature has expanded the grounds for revocation, suspension or limitation of a medical license to include failure "to inform a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment specified in the standard summary supplied by the board. . . ." The Kansas State Board of the Healing Arts is to develop and distribute such a summary to physicians licensed in the state. The summary will outline alternative modes of therapy, including surgical, radiological or chemotherapeutic treatments and the attendant risks. This legislation is not to be construed "to empower or authorize the board (of the healing arts) to restrict in any manner the right of a person licensed to practice medicine and surgery to recommend a method of treatment or to restrict in any manner a patient's right to select a method of treatment. (S.B. 623)

HEALTH CARE COST CONTAINMENT MEASURES*

Part 1. **Hospitalization Plan Design**

1. Get rid of first dollar coverage
2. Second opinion surgery — pay 100% of doctor fee for second opinion before surgery
3. Penalty for unnecessary weekend admission to hospital — change the co-insurance percentage
4. Higher deductibles — get more cost participation from the employee
5. Include coverage for outpatient surgery, lab tests, pre-admission testing, etc., and pay higher co-insurance percentage
6. Include coverage for
   — birth control pills
   — birth control operations
   — in-office procedures by attending physicians
   — home health care and hospice
   — ambulatory surgery centers
   — out-of-hospital convalescent care
   — free-standing emergency centers
   — treatment for venereal disease
   — home birthing centers
   — mid-wife delivery
   — alcohol and drug abuse
   — immunizations
   — physical examinations (set schedule based on age; everyone doesn't need a physical every year)
7. Don't cover
   — cosmetic surgery or dental unless necessary because of accident
   — eyeglasses or hearing aids, artificial eyes, contact lenses
   — expenses due to act of war, employment, etc.
   — travel when ordered by physician
   — pre-existing conditions for one year — including removal of tonsils and/or adenoids
8. Identify best care for money facility, and pay higher co-insurance when care is received there
9. Offer several different plans: ie, good, better, best, and charge accordingly
10. Base deductibles and out-of-pocket limits on salary level — stop loss and co-insurance can remain constant
11. Pay usual, reasonable, and customary charges
12. Pay semi-private room rate
13. Include a subrogation clause — for cases where the employee may be reimbursed through lawsuit
14. Don't cover luxury items: ie, TV's, telephones, extra beds, etc.
15. Include C.O.B. (coordination of benefits) clause
16. Limit emergency care to within a stated number of hours after accident if accidents have higher co-insurance than regular coverage
17. Pay higher co-insurance when generic drugs are purchased
18. Offer a percentage of deductible rebate if not used over a period of one year
19. Offer to pay employees a percentage of recovery on mistakes they find on medical bills

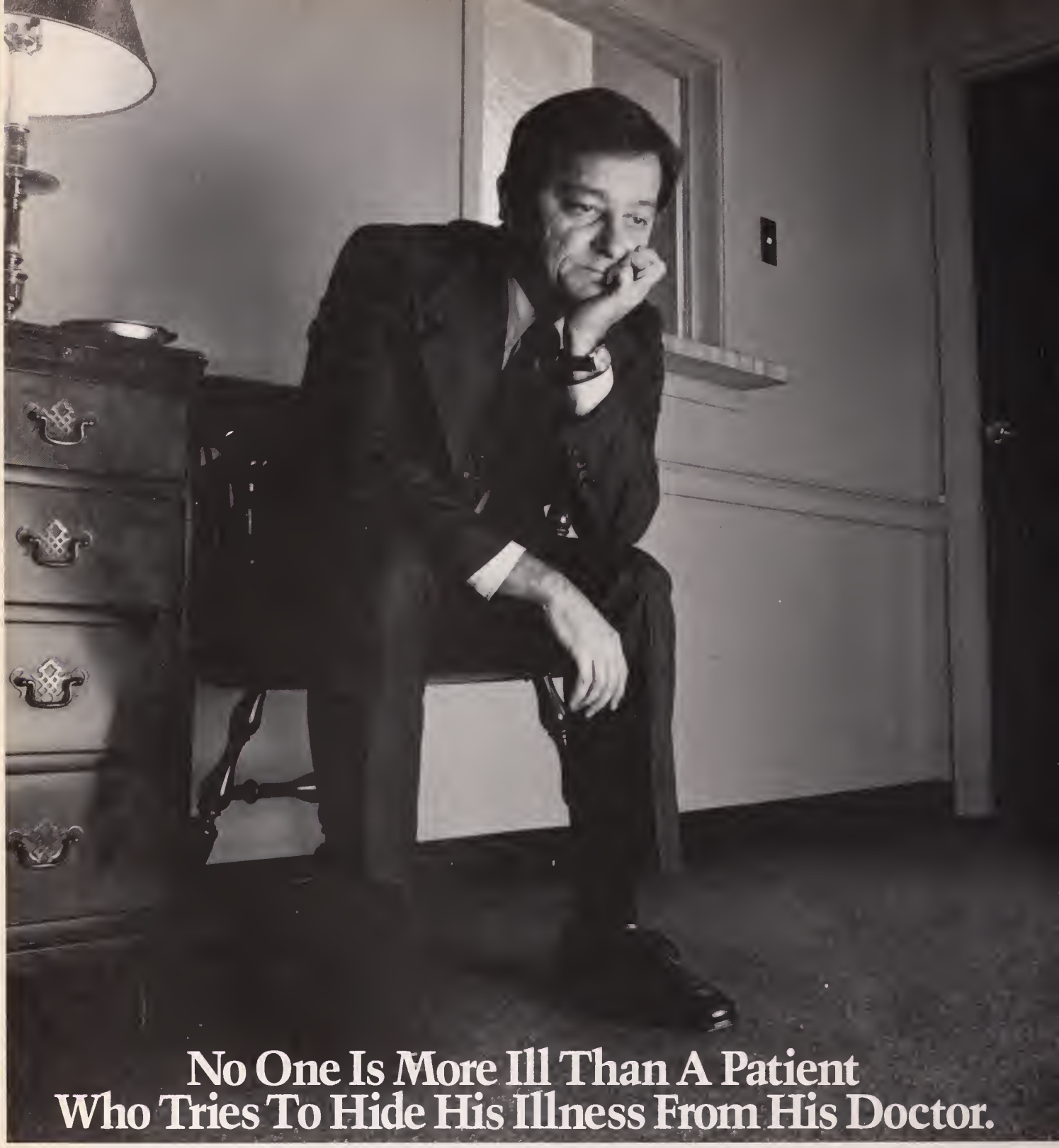
* From suggestions compiled at Mississippi Manufacturers Association seminar, "Managing Health Care Costs in Mississippi," Sept. 20, 1984.

HEALTH CARE COST CONTAINMENT MEASURES*

Part 2. **Internal Company Programs, Policies and Procedures**

1. Train employees to accept responsibility for their own good health
2. Encourage every imaginable preventive measure
3. Encourage employees to discuss price — shop for medical care
4. Negotiate with physicians on reduced rates — then offer incentives for employees to use those physicians
5. Pursue Preferred Provider Organizations (PPO's)
6. Pursue Health Maintenance Organizations (HMO's)
7. Establish an internal claims audit function and procedures
8. Offer seminars and possibly offer reduction of monthly premium for employees to attend seminars on:
   — nutrition
   — smoking cessation
   — proper dieting
   — weight control
   — weight loss
   — first aid
   — cardiopulmonary resuscitation (CPR)
   — physical fitness
   — stress management
   — proper running techniques
   — proper lifting techniques
   — effects of alcohol and drug abuse
   — hypertension
   — etc.
9. Pursue an Employee Assistance Program (EAP)
10. Conduct on-site Health Fairs
11. Establish an on-site medical or health services function part-time or full-time as needed
12. Establish a system to monitor employee health costs (track patterns)
13. Establish system and schedule for periodic blood pressure checks and follow-up
14. Have a company blood donor plan — (1) have everybody participate or get a substitute and (2) possibly offer price reduction on monthly premium for those who donate
15. Review the food available on site
    — have nutritious and dietetic food available in cafeterias and vending machines
    — remove salt shakers from tables
    — offer salad bars, fruit juices, etc.
16. Establish communication system with facilities' provider for workers' compensation cases
17. Investigate availability of services from health care facilities in regard to OSHA requirements: ie, hearing conservation, environmental pollution, lead levels, caustic materials, etc.
18. Develop or purchase a WELLNESS program — some companies are building their own exercise facilities

* From suggestions compiled at Mississippi Manufacturers Association seminar, "Managing Health Care Costs in Mississippi," Sept. 20, 1984.



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Chiropractic Scores Partial Victory In CHAMPUS Legislative Negotiations

Representative G. V. (Sonny) Montgomery was one of three congressional conferees who successfully fought provisions to include full chiropractic coverage as a benefit in military hospitals and CHAMPUS coverage. But it was only a partial victory for those opposed to chiropractic benefits.

In its final form, compromise legislation agreed upon in September by House and Senate Conferees directs the Defense Department to develop several demonstration projects to assess the value of including chiropractic as a benefit. Sen. Strom Thurmond was the major supporter of legislation favoring the addition of chiropractic coverage.

The provision is contained in the 1985 Defense Authorization Act, and it marks the first time a directive involving chiropractic has been included in such legislation.

Congress has directed that the demonstration projects be conducted in consultation with the secretary of the Department of Health and Human Services. Chiropractors are classified by HHS as category 1 providers, as are physicians and dentists.

The conference report declared that the demonstrations should be "broad in scope" and include enough data for reaching a future decision on providing full chiropractic coverage in uniformed service facilities and under CHAMPUS.

Biloxi is Site for Next Month's Tri-State Thoracic Conference

Twenty eight speakers from medical centers throughout the United States will be featured at the 29th annual Tri-State Thoracic Case Conference to be held January 18-19, 1985 at the Biloxi Hilton Hotel.

William C. Pinkston, M.D. of Jackson, Mississippi Thoracic Society secretary/treasurer, is serving as Mississippi's conference chairman. The two-day event, co-sponsored by Lung Associations and Thoracic Societies of Mississippi, Alabama, and Louisiana and the University of Mississippi School of Medicine, is a professional educational conference for physicians of the three-state area.

T. K. Williams, M.D. of Jackson, MTS president, announced that Mississippi physicians featured on the program will include Hoyt J. Burdick, M.D., William C. Hays, III, M.D., John J. White, M.D. and Joe R. Norman, all of Jackson; Major Patrick J. Savage, M.D., M.C. and Major Charles A. Duncan, M.D., M.C., both of Keesler Air Force Base Medical Center.

David J. Pierson, M.D., Medical Director, Respiratory Therapy Department, Harborview Medical Center, Seattle, Washington, will deliver the keynote address, "Practical Aspects of COPD."

Special out-of-state guest consultants for the conference include Harold Urschel, Jr., M.D., University of Texas Health Sciences Center, Dallas; Leonard H. Seitzman, M.D., San Antonio State Chest Hospital, Texas; and Andrew Flint, M.D., University of Michigan School of Medicine. Other program participants include physicians from Louisiana and Alabama.

Physicians interested in further information should contact the Mississippi Thoracic Society, P.O. Box 9865, Jackson, MS 39206.

Dr. Triplett Appointed To AMPAC Board

Dr. R. Faser Triplett of Jackson has been appointed to a term on the American Medical Political Action Committee (AMPAC) board of directors.

Dr. Triplett, a former MSMA president, currently is serving as delegate to the AMA House of Delegates, representing the American College of Allergists. He has served as president and chairman of the board of the Medical Assurance Company of Mississippi since its inception in 1976.

The Louisville native received his B.A. degree in political science from the University of Mississippi and the M.D. degree from Tulane University School of Medicine. He is a diplomate of the American Board of Pediatrics and the American Board of Allergy and Immunology, and is clinical assistant professor of pediatrics at the University of Mississippi School of Medicine.

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

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Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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PERSONALS

James Achord of UMC spoke at a meeting of the Ochsner Medical Foundation in New Orleans recently.

Thomas Barkley of New Albany was selected to participate in the Leadership Mississippi program of the Mississippi Economic Council.

Malcolm Davis Baxter of Hernando has been recertified by the American Board of Family Practice.

John R. Bise of Jackson conducted a roundtable discussion at a clinical meeting of the American College of Obstetricians and Gynecologists in San Francisco recently. He was elected to membership in American Society for Laser Medicine and Surgery at its annual meeting in Salt Lake City.

Bertin C. Chevis of Bay St. Louis has been named chief of staff at Hancock General Hospital.

Richard H. Clark of Hattiesburg received the sixth Hub Award presented in recognition of outstanding contributions to the community.

Wallace Conerly spoke at a meeting of the Eupora Rotary Club recently.

R. A. Dale of Hazlehurst has been named chief of staff of Hardy Wilson Memorial Hospital.

J. Berlyn Edwards of Ocean Springs has been named president of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

Gary G. Gordon of Meridian has been certified by the American Osteopathic Board of General Practice.

Candace E. Keller has associated with Joseph B. McMillon, Katherine S. Aldridge, James R. House, William B. Strong, Bobby D. Smith and Robert C. Strong for the practice of anesthesiology at 2601 Mamie Street in Hattiesburg.

G. N. Kini has associated with Aberdeen Medical Clinic, 501 South Chestnut Street, for the practice of internal medicine.

Ellen McDevitt of Gulfport received the Medal of Excellence presented by the Mississippi University for Women.

William C. Nicholas of UMC conducted seminars in Natchez and Vicksburg and participated in a radio interview in Hattiesburg. He participated in the American Diabetes Southern District Meeting in Atlanta and the 19th Conjoint Scientific Assembly of the Maritime Chapters of the College of Family Physicians, held at Prince Edward Island, Canada.

Chere H. Peel has associated with Jackson Multispecialty Clinic, 1050 N. Flowood Drive, for the practice of Internal Medicine.

Adrienne J. Preston has associated with Singing River Neurological Surgery, P.A., in Pascagoula, for the practice of neurology.

Philip Rast announces the opening of his office for the practice of urology at 439 North Jackson Street in Brookhaven.

David Savell of Meridian has been certified by the American Board of Pediatrics.

James A. Sheffield of Gulfport has been recertified by the American Board of Pediatrics.

Mike Shaheen of Sardis was honored with a reception on "Dr. Mike Shaheen Day" in October.

Thomas E. Stanford has associated with Internal Medicine Associates of Tupelo (845 South Madison Street) for the practice of internal medicine.

Plez Tinsley of Meridian presented a paper at the Fifth Internal Symposium on the Facial Nerve in Bordeaux, France.

William C. Touchstone of Belzoni announces the association of Leon Aron for the practice of family medicine.

James C. Waites of Laurel has been named president-elect of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

Lamar Weems of Jackson will be taking educational sabbatical leave from University Medical Center from January 1-June 30. He will be visiting professor at Duke University during that time.

DEATHS

Ehrich, Melvin, Clarksdale. Born Newark, NJ, Oct. 14, 1922; M.D., Chicago Medical School, Chicago, 1950; interned and pediatric residency, Charity Hospital, New Orleans, 1950-53; died Oct. 24, 1984, age 61.

PLACEMENT SERVICE

Physicians Wanted

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PRACTITIONER wanted to locate in Heidelberg, MS. Community furnished clinic, service area of 13,000, and near metropolitan community. Contact: C. Rosenblatt, 4126 Navajo Rd., Jackson, MS 39211 or call (601) 362-9673 or 362-5852.

EMPLOYMENT OPPORTUNITY. CHIEF MEDICAL OFFICER. Salary: negotiable. Location: Choctaw Indian Reservation in Pearl River Community, 8 miles west of Philadelphia, MS. Minimum Qualifications: Must have a degree of Doctor of Medicine from an approved U.S. or Canadian medical school or a degree of Doctor of Osteopathy from an approved school of osteopathy. Must obtain a full unrestricted license to practice medicine and surgery in the state of Mississippi. For more information contact James M. Cox, Mississippi Band of Choctaw Indians, Route 7, Box 21, Philadelphia, MS 39350; telephone: 601-656-2211, ext. 129.

FAMILY PRACTITIONER wanted for North Central Mississippi town of Charleston. Population 3,000; Tallahatchie County population approximately 25,000. This is a well-equipped 45-bed hospital with a 30-bed extended care facility. Opportunity for private practice or in established clinic with two physicians. Contact F. W. Ergle, Jr., Administrator, Tallahatchie General Hospital, Charleston, MS 38921; phone (601) 647-5535.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

53-year-old ABFP, on Mississippi Gulf Coast, needs board certified/qualified family practitioner as associate or partner. Financial arrangements negotiable. Please send information to Box K c/o JOURNAL MSMA.

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Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact one of the following Medical Relations Officers: Henry Klar (Ext. 2276) or Martina Mayfield (Ext. 2227).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.

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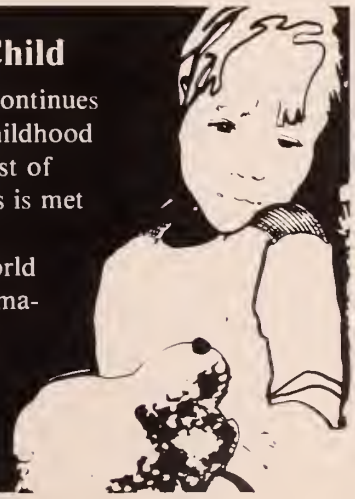

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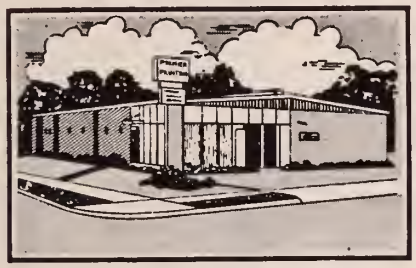

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IN CONCLUSION

Nearly one-fourth of all nonfederal patient care physicians, excluding residents, had some financial arrangement with hospitals, the AMA's Socioeconomic Monitoring System reports. SMS data show that 24.2% of physicians received part of their practice income by direct payment or through a lease arrangement with hospitals. More than 60% of all physicians with a hospital contract have a salary arrangement, while 41.1% have a fee-for-service arrangement. Of those with hospital arrangements, 7.5% receive income from a percentage of gross billings.

The AMA has set up a professional liability hot line (800-552-4642) to allow members to communicate directly with AMA staff about malpractice and professional liability issues. The line is a project of the special task force created to coordinate AMA activities in this area. Report 2 of the task force, published in the November 23/30 issue of "AM News," examines two questions: whether or not a stable insurance market can be maintained and whether or not tort reforms are effective in addressing the professional liability problem.

Nicotine chewing gum is twice as effective as placebo in helping smokers who wish to quit, according to a report in the November 22 issue of JAMA. In the first report of its kind, 29% of those who used the nicotine gum remained abstinent after one year compared with 16% of those treated with placebo. Successful use of the gum depends on appropriate instructions, expectancies, and adjunct therapies. The gum is contraindicated only for those with severe cardiovascular disease and pregnant women.

Even though smoking causes 350,000 excess deaths in the U.S. each year, it rarely appears on death certificates as a contributing factor. In the November 22 JAMA, two authors urge physicians to indicate the role of tobacco use in the deaths of their patients. This information on death certificates would improve vital statistics, epidemiology and public health, they maintain. "Cigarette smoking is now the most serious, as well as the most widespread, form of addiction in the world," they conclude.

Linguistic analysis of language used by the aged may offer the best answer to whether aging is a natural process, the result of a continuum of minor pathological insults, or a combination of both, says an article in the November issue of Archives of Neurology. The author points out that some writers use more verbs and fewer adjectives as they age, and that the aged often use fewer different types of words within language blocks that do young adults.

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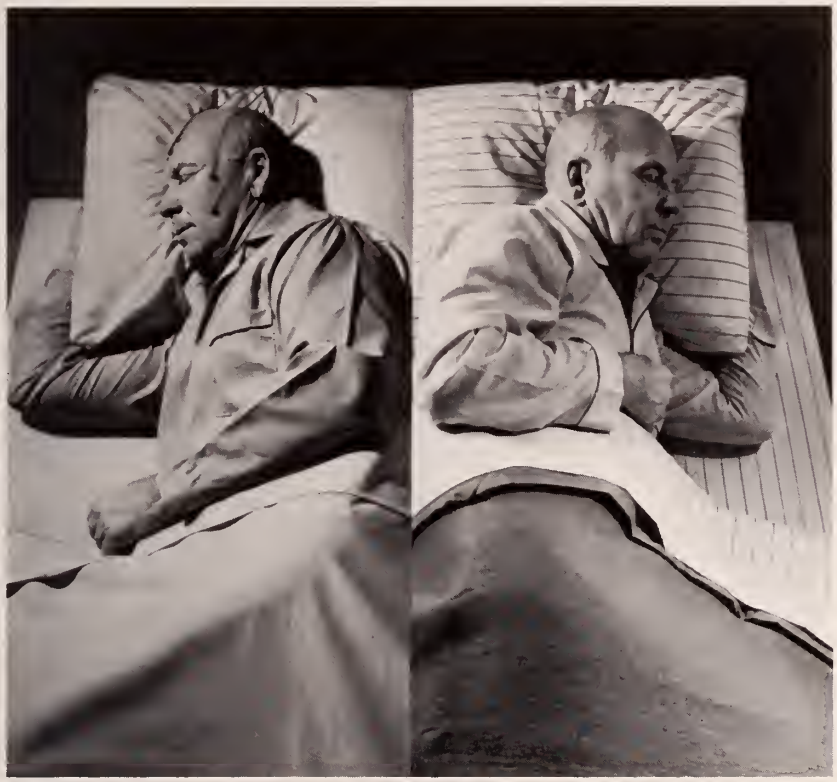

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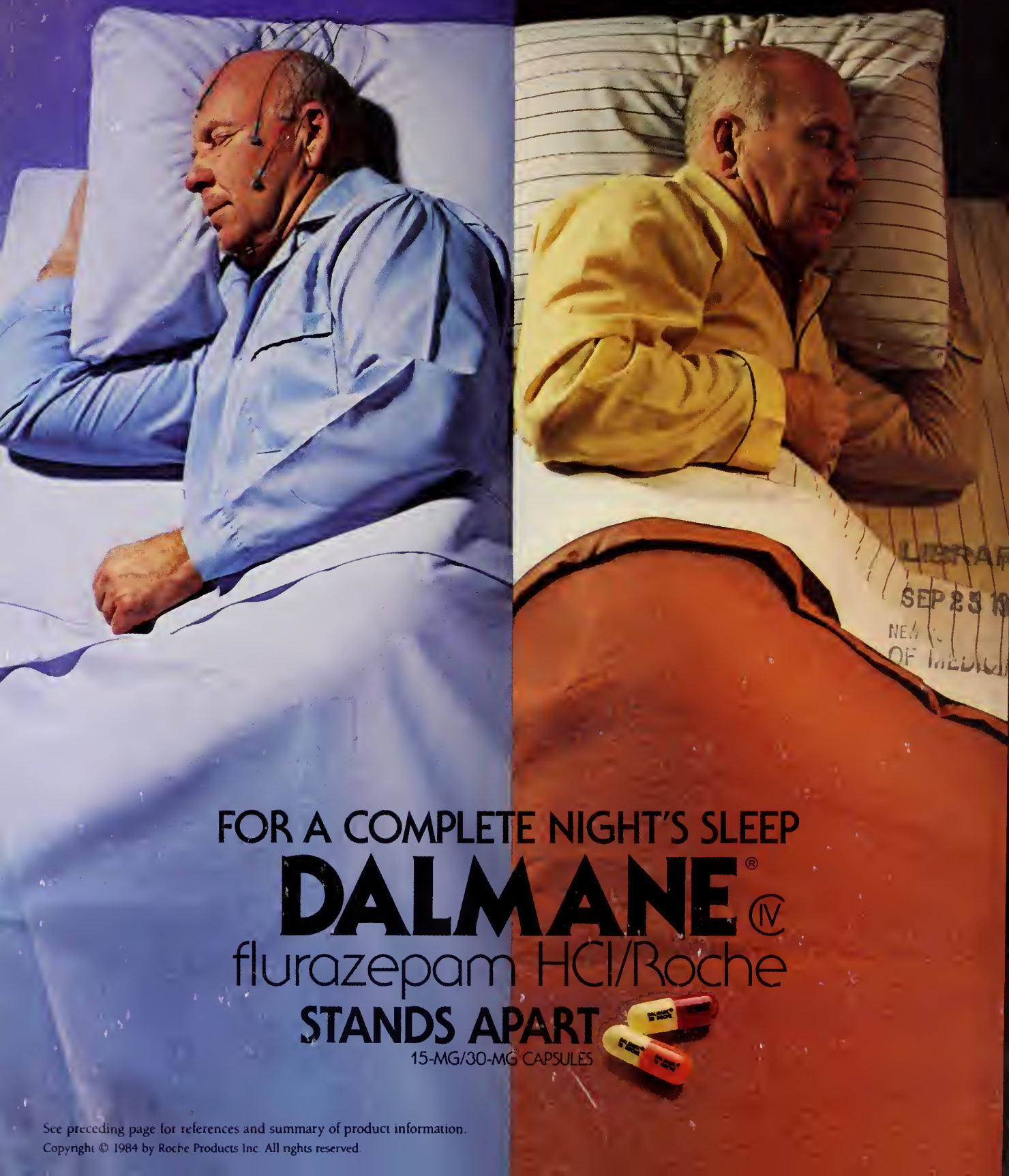

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